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Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

Original Communications.

LAPARO-ELYTROTOMY.*

BY J. N. M'CORMACK, M.D.,

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Although elaborate articles on this and kindred obstetrical topics by Drs. Thomas, Parvin, Garrigues, and other distinguished contributors to the medical press have recently appeared, I hope to collect some facts in regard to this operation from these and other sources which in a condensed form may not be wholly unacceptable to the profession. When we consider the high rate of mortality that has, until quite recently, attended all operative procedures in which the abdominal cavity was opened, and the prejudice that has always existed in the profession against any obstetric operation particularly which involved the peritoneum, we can but be surprised that propositions repeatedly made and tried of sub-peritoneal methods of removing the ovum, as substitutes for the cæsarean operation,

* Read before the Tri-States Medical Society in 1880.

should have, with the exception of symphysiotomy, attracted so little attention at the time they were made, and been soon allowed to fall into an oblivion so complete that subsequent obstetric writers either do not mention them at all or speak of them as curious experiments which it is their duty to condemn. Thus we find that, so late as 1867, Stoltz, one of the most eminent of European obstetricians, says in reference to the methods of Jöry, Rityen, and Baudelocque, "These eccentric modes of performing the cæsarean operation have been devised for the purpose of saving the peritoneum and the uterus from the lesions to which failures have generally been attributed. It was easy to foresee that openings so small, made just above the brim, would not suffice for the extraction of the fetus, and that incisions of the vagina and of the lower segment of the uterus would encounter insurmountable difficulties." In less than three years from the time this language was used Dr. T. G. Thomas demonstrated the fallacy of these theoretical objections by delivering after this method a living child from a living woman.

A brief history of the origin and progress of the various subperitoneal methods may be of some interest in this connection.

In the sixteenth century Pineau, a French surgeon, suggested a section of the pubic symphisis as a means of securing increased space in cases of difficult labor from deformed pelvis, in place of cæsarean section. In 1768 Sigault, then a student of medicine at Paris, having imbibed the opinion of the earlier anatomists that the ligaments of the pelvis gave way during parturition, formally proposed this operation in a communication to the Royal Academy of Surgery. The proposition was condemned by the most eminent members of that body as unjustifiable, but Sigault, nothing daunted, maintained the advantages of this method in an inaugural thesis at Angers in 1773, and in 1777 put his theory to a practical test by performing the operation on a living woman. The child was born alive, and the woman was shown to the medical faculty six weeks afterward apparently well. For a time every thing was changed. Sigault was lauded

as a benefactor. A royal pension was granted him, and the Academy of Medicine presented to him and his assistant, LeRoy, a gold medal, which spoke eloquently their appreciation of his discovery. The press teemed with panegyrics of the medical hero, and some of his more ardent admirers claimed that nothing less than divine inspiration could have led his mind to this wonderful conception. A fierce war was waged for and against the operation, but after being performed frequently on the continent and a few times in England it was very generally abandoned, as the section of the symphysis gave very little increased space in the pelvis and the woman was usually left maimed for life.

In 1832 Galbiati, of Naples, operated by a modification of this method, dividing not only the symphysis, but also sawing through the rami of the pubis and ischium on the right side; and when, on the following day, it was found that the space was still insufficient, the bones of the left side were divided also. The child was now found to be dead, and was delivered by embryotomy. The woman died two days afterward. A similar operation, though still more cruel, was performed by Ippolyty, of Naples, in Galbiati's presence, in 1843, with a like unfortunate result.

Many modifications as to the location and direction of the abdominal and uterine incision in making the cæsarean section had been made by Platner, Varoquier, Lauverjat, Sabatier, and others without any idea of avoiding the incision of the peritoneum or uterus, when, in 1807, Jöry was led, by observing that the fetus sometimes escaped into the abdominal cavity after rupture of the vagina, to suggest that the abdominal incision should extend from the spine of the pubis to the anterior spinous process of the ilium, and then, instead of the ordinary uterine incision, that the upper part of the vagina should be opened, and delivery effected through the os uteri, which should be divided if necessary. He performed the operation on the cadaver, and experienced no difficulty in the delivery after incising the os uteri. This method was never tried on the living subject.

In 1820 Rityen proposed, as an improvement on the suggestion of Jöry, that the peritoneum be lifted out of the way and the vagina opened directly, so as to make the operation truly subperitoneal. He attempted to operate in this way the following year, but in making the necessary enlargement of the vaginal incision posteriorly the hemorrhage was so profuse that he performed the cæsarean section, and delivered a living child, the woman dying on the third day. Rityen displayed great ingenuity in planning his operation, and in the report of the case in 1825 he gave detailed directions for its performance, which do not materially differ from those given by Thomas, except that Rityen enlarged the opening in the vagina by incision instead of by laceration. He believed that the oblique incision in the abdomen would not give sufficient space, and suggested a longitudinal one to connect with this.

In 1822 Dr. Physick, of Philadelphia, proposed a method of rending and incising the uterus without wounding the peritoneum, but he made no attempt to test its value in practice.

In 1823 L. A. Baudelocque published a thesis on this subject, and twenty years later he made two attempts to perform the operation. In his first case his experience was similar to Rityen's, the incision of the vagina being followed by so furious a hemorrhage that he opened the uterus in the ordinary way, delivering a dead fetus, followed by the death of the mother a few hours later. In his second case he completed the operation by the sub-peritoneal method, after tying the internal iliac, and delivered a dead fetus. The mother lived seventy-four hours. He added to the report of these cases one of lateral rupture of the vagina, to show, as he says, that incision or rupture of that canal laterally would be necessarily followed by fatal hemorrhage. Discouraged by his experience in these cases, he rejected the subperitoneal methods entirely, and suggested instead an operation which is virtually that of Jöry.

In 1857 Gianplome, of Italy, reported a case in which he made an incision in the linea alba from near the pubis upward

about three inches, and a transverse cut at the lower end of this. He reports the case as gastro-elytrotomia, but gives no details as to how or where the vagina was incised or how the delivery was effected. The child was alive and well developed, but the mother died in less than twenty-four hours.

It will be seen by what has been said that the operation in variously modified forms had been independently conceived by a number of distinguished obstetricians; that it had been attempted by Rityen once, by Baudelocque twice, and by Gianplome once; and that after these attempts it had been allowed to pass so completely from the notice of the profession that Dr. Thomas had tested the operation on the cadaver before he became aware of the fact, almost accidentally, that any one had preceded him in this field by attempt or even suggestion. To Dr. Thomas then is due all honor as an inventor; for his was the wisdom to devise, his the skill to execute, and his the confidence to defend the operation until it has almost become an established procedure in our art.

The history of the operation since its revival begins with the paper read by Dr. Thomas in 1870, based on three operations on the cadaver and one on a woman moribund from pneumonia. In the latter case the feasibility of the operation was fully demonstrated, the child being delivered alive and the woman dying from causes entirely independent of the operation.

In 1874 Dr. Skene, of Brooklyn, operated on a primipara with an antero-posterior diameter of two and a half inches, who had been forty-eight hours in labor. The child was dead and the mother almost moribund when the operation began, previous attempts at delivery having been made by both version and craniotomy before Dr. Skene was called. The woman died in seven hours.

In 1875 Dr. Skene operated on a woman with an antero-posterior diameter of two and three fourths inches, who had been delivered once by craniotomy and twice by inducing labor before the end of pregnancy. Both mother and child recovered.

In 1877 Dr. Skene operated on a primipara with an antero-posterior diameter of one and a half inches, who had been in labor four days. This was an unfavorable case in almost every respect. The woman's general condition was bad. Both hips were anchylosed. The thighs were flexed at almost a right angle with the body, and the knees could not be separated more than one and a half inches. Previous intra-pelvic inflammations had obscured all the normal anatomical points, the organs being glued together by inflammatory products. These were supplemented by hygienic surroundings equally unfavorable, and yet both mother and child recovered.

In 1877 Dr. Thomas operated on a very small and poorly-developed primipara with an antero-posterior diameter of two and a half inches, who had been in labor sixteen hours, saving both mother and child.

In 1879 Dr. Gillette operated on a primipara with an antero-posterior diameter of one and a half inches, who had had more or less pain for a week. The fetus was in an advanced state of decomposition, and much difficulty was experienced in effecting the delivery, success being at last attained by the use of the cephalotribe and cranioclast. The woman recovered.

In 1879 Dr. Himes, of Sheffield, England, operated on a badly-nourished woman of intemperate habits, who had cancer of the rectum and vagina, with a fistulous opening between the two canals. The operation was performed almost entirely in the interest of the child, which was saved.

In 1879 Dr. Edis, of London, operated as an alternative to embryotomy in a case of deformed pelvis in which delivery by the use of the forceps had been previously attempted. The general condition was bad and the woman much exhausted. The woman died, but the child was saved.

It may be proper to add in this connection that Dr. J. T. Everitt, of Stirling, Illinois, performed this operation successfully in 1879 for the removal of a calcified fibroid of the uterus.

Viewed in the light of its success since its revival by Dr. Thomas, the operation is certainly entitled to the serious consid-

eration of the profession as a conservative procedure. It has been performed eight times as an obstetric procedure, with a saving of four women and six children. Even these figures, favorable as they are, are far from representing the truth as regards its success. Of the four women who were lost, one was moribund and two others almost so when the operations were begun, and the other had such extensive cancerous disease of the rectum and vagina, taken in connection with her general health and habits, as to insure the failure of any attempt at saving her life. All the children were saved which were alive when the operations began.

Can embryotomy or gastro-hysterotomy show a more favorable record than this? If we include in our list only those cases in which success can justly be attributed to the operation itself, as Dr. Harris has very properly done in making up his tables of the cæsarean section, can either of those operations make so good a showing? The dangers in this operation are from hemorrhage, shock, and septicemia. Of these it may be said that troublesome hemorrhage has not occurred in any of the recent cases, which was probably due to the fact that the vagina was lacerated, and not incised, as we have already seen was done by Rityen and Baudelocque. Time alone can determine whether or not this method of opening the vagina effectually protects against hemorrhage, and until this is done the operator must be prepared to meet it, for it must be borne in mind that fatal hemorrhage has not infrequently occurred after rupture of the vagina during labor. As the peritoneal cavity is not opened, the danger from shock is not great, and the facilities for drainage reduce the danger from septicemia to a minimum.

A wound of the bladder or urethra is an unpleasant accident that has occurred in four out of the eight cases. True, the wound healed spontaneously in nearly all of them, but this accident is so unpleasant in the lying-in chamber that it is of great importance to the success of the operation for the future to demonstrate that its occurrence may generally be avoided.

Probably no more fitting language can be selected with which

to close this paper than that of Dr. Thomas when he said, "I do not regard the claims of laparo-elytrotomy to be established as a standard operation as yet proved, but that as now sufficiently tested by experiment to deserve serious consideration at the hands of the profession."

BOWLING GREEN, KY.

MONGREL OR HYBRID FEVERS.*

BY CHARLES T. REHER, M.D.

S. G., aged twenty-seven, adult male, farmer, always had good health, healthy parentage, was attacked August 16th with a chill, well marked, without any premonitory signs. Chill lasted about an hour, followed by a hot fever of about four hours' duration, the fever followed by a sweat. Took twenty-four grains of quin. sulph. in four-grain doses before chill-time next day. No chill this day. Felt tolerably well until the third day, when there was another slight chill seven hours earlier in the day than the previous chill, followed by a severe fever lasting seven or eight hours. Administered five grains of quin. sulph. every three hours until forty grains had been taken. Patient felt tolerably well until the fourth day, when the third chill appeared two hours later in the day than the first chill, followed by fever of a high grade, and which continued for twenty-seven days, grade irregular, sometimes higher than at other times, unless when arrested by large doses of quin. sulph., but always reappearing in from ten to twenty-four hours after ceasing the administration of the antipyretic. After the twenty-seventh day there was no febrile disturbance for five days. The patient appeared to be fully convalescent, when again a very severe chill occurred. Thirty grains of quin. sulph. was again

* Read before Tri-States Medical Society.

given in three-grain doses, but on the fourth day following there was another and the final chill, followed by complete recovery. During the first week of the continued fever there was some troublesome epistaxis; there was diarrhea during the second and third weeks, some abdominal tenderness, no tympanitis, tongue characteristically typhoid, slight delirium occasionally.

This case was at first diagnosticated as one of intermittent fever, next as a remittent, and lastly as a malarial-typhoid. Alas! what distress an early and a hasty diagnosis may bring upon us! and the same holds good when we are cumbered with an erroneous etiology and pathogenesis. Was there in this case a specific germ that caused all these disturbances—the so-called malarial, as well as the typhoid? or were there two different yet specific germs at work at the same time? The malarial element was plainly present from first to last; the typhoid element was present with equal certainty from a point about one week after the beginning to a point about a week prior to the termination of the attack. The malarial held possession, while the typhoid worked out its self-limited period.

Nearly all, if not all, the cases of fever to which the term typhoid applies, occurring in this region of country, are of this mixed, mongrel, or hybrid character. In a recent work on Practice by an eminent author the term typho-malarial does not appear in the index. However, in the body of the book, immediately following the "treatment" of typhoid fever, we find this note: "*Note.—Typho-malarial Fever.* By this term is meant typhoid fever complicated with a malarial element. In consequence of the existence of a malarial infection the *symptomatology* of typhoid fever is modified, the chief deviations from the usual thermal line consisting in the greater excursions of the daily temperature. This modification of the fever has long been known by all well-informed physicians practicing in malarious regions. Dr. Woodward, of the Army, the medical officer in charge of the medical history of the War of the Rebellion, gave to this combination the name *typho-malarial fever.* In his first publication on this subject Dr. Woodward supposed that there

was something *distinctive* in this form of fever, and that its morbid anatomy differed in important particulars from that of typhoid. . . . . In a paper read before the International Medical Congress, at Philadelphia, Dr. Woodward retracted his original observations, admitted that he had been misled, and that the morbid anatomy of typho-malarial fever is merely that of typhoid. Typho-malarial fever has then no reason to be admitted as a morbid entity in nosological systems; does not, in fact, exist. All that can be claimed for it is, that when typhoid fever occurs in an individual saturated with malaria the fever is modified somewhat in its course, has more of the remittent type, and is apt to be protracted, owing to the occurrence of intermittents during convalescence. The introduction of the term typho-malarial was unfortunate, the more especially as, since the claim for its distinctive type having been permitted to go *uncorrected* for ten years, it has been widely received, generally employed, and has therefore years of usage to enhance its duration."

As another example of the same author's high regard for consistency with previously-expressed opinions and for the long-taught notion that the so-called malarial diseases are caused by a specific disease-germ, I will here also give his definition of malarial diseases, thus: "*Malarious Diseases—Intermittent and Remittent Fevers.* Definition: Malarial Fevers are characterized by their prevalence in certain regions of the world known to produce the poison *malaria*, by their periodicity, and by the regular succession of the cold, hot, and sweating stages." I mean no disrespect to the distinguished author when I ask, Is this a definition of malarial diseases? Do intermittent and remittent fevers (the only diseases enumerated by the author under the head of malarial diseases) cover the whole subject? Can we make any claims for scientific medicine by such a lame and imperfect and incomplete presentation of so important a disease? What is gained by *defining* the disease as being characterized by "periodicity and the regular succession of the cold, hot, and sweating stages," and then enumerating an almost endless vari-

ety of types which discredit the definition, even treating of "masked intermittents" and "*substitution diseases!* hematuria, pulmonary hemorrhage, bronchitis, coryza, iritis, jaundice, diarrhea or dysentery, vomiting, urticaria, roseola, and numerous other maladies," "neuralgias, angina pectoris, spasms, delirium, mania, hallucinations, coma, vigil, etc.," the "algid, choleriform, diaphoretic, pneumonic, nephritic, and cerebro-spinal" forms or types—huge mountains resting on a foundation of straw!

It is stated or admitted in the "note" that in typho-malarial cases the system is infected by malaria, and it is also certainly infected by the typhoid poison; nevertheless the author asserts that it (typho-malarial fever) "does not in fact exist." Is not this something that is very puzzling and contradictory? The author means to say that typho-malarial fever should not be recognized (nosologically) because it has no special morbid anatomy by which it can be distinguished from ordinary typhoid or enteric fever. It should be borne in mind that the morbid anatomy of attacks of the common types of malarial fevers differs from that of typhoid fever really only in degree, and this difference is probably due to the longer duration and the persistently high grade of the fever in the latter. Every practitioner is well aware of the fact that there are clinical or *symptomological* features by which the typho-malarial is readily distinguished from the true typhoid; and since the recognition of the true nature of a disease is a matter of vital importance with a view to a judicious therapeusis, it is difficult to understand why there should be objections to a proper nosological recognition of this hybrid disease.

But the point or question of the first importance is, are there two distinct specific poisons present and active in the system at the same time? Denying the possibility of two such poisons disturbing the organization, each in its peculiar way, at the same time, some eminent physicians claim that no such disease as typho-malarial fever can have existence. The author to whom reference has been made admits the presence of two poisons, only claiming, on the ground of its having no distinctive patho-

logical anatomy, the disease should not have accorded to it nosological recognition. If we will only permit ourselves to know that the so-called malarial diseases are diathetic neuroses from climatic or meteorological causes, with various, almost innumerable exciting causes, we shall have small difficulty in extricating ourselves from this labyrinth of puzzling contradictory hypotheses and indefensible positions, and this highly-important subject shall be freed from the fogs and clouds of erroneous notions, in order that it may be viewed and comprehended in the clear light of scientific fact, by means of the key furnished by the physiology of the nervous system.

We have recently been informed that eminent authorities are now placing gout among neuroses. The so-called malarial diseases also belong to that class.

SHELBYVILLE, ILL.

A CASE OF SUPPURATIVE HEPATITIS — DEATH — POST MORTEM.

BY J. M. LITTLER, M.D.

N. W. B., a physician fifty-three years old, bilious temperament, for two years past suffered from general ill health, and had been usually known as a dyspeptic. As a physician he treated his own ailments, which he thought due to a dormant liver and malarious cachexia, his favorite treatment being calomel and quinia often repeated. For years he was subject to obstinate constipation, and his treatment was calomel to move the bowels, then opium to check the catharsis caused by the calomel. For several years he had an abnormal appetite, which he indulged, and, having lost his teeth, did not masticate his food well. For two years there had been a jaundiced condition of the skin and conjunctiva, partially disappearing at times

When constipated the stools were clay-colored, but when catharsis was produced biliary in character. For some time prior to death the patient complained of pain in the right arm and shoulder. This may, however, have been the result of an attack of rheumatism in early life, and not a symptom of hepatic disease.

On November 11, 1879, while visiting a patient, the doctor had a severe chill, followed by high fever; the next morning another chill. Dr. S. was called to see him, and found a temperature of 104°, pulse 100, tongue coated, and diarrhea. The patient thought he merely had an ague chill, but this time the fever did not abate, and the following morning he had another chill. The symptoms of the previous day continued, and in addition the patient became intensely jaundiced, so that the skin was almost black, and the urine was nearly as dark as the skin. Dr. B. now believed he was laboring under an attack of typho-malarial fever, which diagnosis was not concurred in by his physician or his visiting brethren. The chills came at irregular intervals—every day, every other day, and sometimes two or three in one day. Quinia and other antipyretics were freely used without effect. The temperature varied from 100° to 104°, without regularity as to exacerbations and intermissions. Sometimes after a chill a high temperature would persist for several days, and again there would be only a slight fever for several days in succession. Antipyretics proved as useless in the fever as in the chills. He appeared dyspeptic, and often a few minutes or an hour after eating would vomit his food. This emesis was not followed by any grave symptom, for often immediately after eating he would order a new supply. The stools varied from obstinate constipation to profuse catharsis. The constipated stools were of a black, tar appearance; the thin stools yellow and watery. The patient slept well when not disturbed by chill or fever; there was at night, however, profuse diaphoresis, which left the patient exhausted in the morning. The urine was normal as to quantity; sometimes dark, then pale, and usually immediately after a chill would be yellow. The

intellect remained clear, although the patient was irritable at times, but hopeful regarding his condition.

On December 25th, in company with Dr. S., I visited the patient and examined him. The general symptoms as detailed above were present. There was no organic disease of the heart. At the junction of the tenth rib with a perpendicular line passing through the right nipple was found a tender spot the size of a silver dollar. The skin was not discolored, but I thought I could detect, by inspection and palpation, a well-defined tumor. These symptoms as narrated persisted until spring, sometimes better, sometimes worse, with no hope of a favorable termination. The disease was palliated only, and on the 23d he was prostrated with an aggravation of all the symptoms, and died July 30, 1880.

I made a post-mortem examination ten hours after death in the presence of seven other physicians. Post-mortem rigidity was well marked, body much emaciated, skin nearly a bronze color. The abdominal walls were much degenerated, only a few fibers of the recti muscles remaining. About six kilograms (two gallons) of a turbid liquid were removed from the abdominal cavity; intestines in a healthy condition; and the stomach contained five deciliters (pints) of a dark color, resembling coffee-grounds. The liver was in its normal position, and was removed with difficulty on account of abnormal adhesions to the stomach, intestines, and especially the right kidney. The liver, as to color, weight, and general appearance, looked normal in every respect. The gall-bladder was entirely absent, and in its place was only connective tissue and a waxy substance of brick-dust color. The cystic duct was obliterated by extensive adhesions to neighboring organs. The condition of the hepatic duct and common bile-duct was not ascertained. On section of the right lobe of the liver two centimeters (three quarters of an inch) deep was an abscess containing four grams (one dram) of laudable pus. Several smaller abscesses were found containing from a few drops to four grams (one dram) of pus.

Remarks. Some of the physicians who saw this case thought

the stomach was the seat of the disease; others the alimentary canal or the liver. The stomach was kept in such an irritable condition by the patient's own treatment with mercury and quinia that it became necessary to use morphia hypodermically to allay pain, and this resulted in the opium-habit. The latter part of the treatment was merely supporting and palliative.

Budd was of the opinion that all hepatic abscesses not caused by external violence must be referred to the roots of the portal veins, as ulceration of the mucous membrane of the stomach, intestines, or bile-duct. Ansley says that in the East Indies hepatitis usually precedes the bowel trouble. Waring affirms that in three hundred fatal cases of hepatitis under his observation eighty-two only were preceded by symptoms of disease of the alimentary canal. Bristowe, Andral, and others give evidence to the same effect. It is safe to infer that the theory of Budd would not hold good in this case. The passage of bile per rectum is proof that the hepatic duct and common bile-duct were not obliterated, and the destruction of the gall-bladder is sufficient to account for the pathological appearances; and is it not possible that the original seat of the disease was the gall-bladder, from thence extending to the liver? Of course a gastro-intestinal inflammation may have extended to the gall-bladder. This theory of suppurative hepatitis is new to me, and I advance it as a suggestion. Impaction of gall-stones in the cystic duct may have caused inflammation and obliteration of the gall-bladder,* but there was no evidence pointing to this as a fact. Was the hepatic abscess of recent date? The uncertain symptoms and the character of the pus indicate that the abscesses were recently formed. Could the morbid process have been prevented? I am led to believe that the disease was aggravated by the patient's indiscriminate use of mercury, and that if he had attended more to his digestion and not "whipped" the liver with mercury every time the stools were clay color, he might have been living today.

MUNCIE, IND.

* See New York Medical Journal, vol. 1, p. 222.

FOREIGN CORRESPONDENCE.

My Dear Yandell: LONDON, January 15, 1881.

I began my last letter with a good grumble at the weather. Now it is only fair that even our much-maligned climate should have its due; therefore I am bound to confess that since I last wrote until now we have been rejoicing in deliciously mild and balmy days and nights; and though Old Sol has been mostly conspicuous by his absence, yet at times he has shone out with quite a summer-like power, bringing back pleasant memories of the brighter season.

From some cause or other—possibly the unusual mildness—the number of smallpox cases in this city is steadily increasing. At present it is the east and northeast quarters of London that are chiefly affected, but a tendency to spread to the northern district is already showing itself, and unless energetic measures are taken, and quickly, we shall have another epidemic. There is no doubt that throughout this country the means of dealing with infectious diseases among the poor are lamentably deficient. A dozen or two of extra cases of scarlet fever are sufficient to fill the available hospitals and drive the parish authorities into the wildest confusion. But grumble as we may at the existing sanitary arrangements, it is perfectly clear that were they carried out the danger of infection would be much diminished. Common sense dictates that it is the height of folly to send a sufferer from smallpox to the hospital in a street cab, and yet this is of every-day occurrence. A servant is taken ill, and the master or mistress without further inquiry dispatches her in a cab to the nearest hospital without considering whether she is likely to be admitted or not, thus endangering her life and the lives of dozens of other people. A case such as this occurred only the other day in a family of good position, and the master of the house may think himself lucky to have escaped with a fine of ten pounds. At every work-house a suitable ambulance is kept, which on the receipt of a telegram would be dispatched at once

to the required locality, and thus the patient might be conveyed to the proper hospital with less danger to herself and none to others.

At the last meeting of the Tottenham local board the district medical officer of health, Dr. Lyndale Watson, reported the outbreak of smallpox in a block of wooden houses known as Ward's Alley. "The house where the disease occurred consisted of two rooms, the space of each room being a little over nine hundred cubic feet, and it had been occupied by a man, two grown-up sons, a son-in-law and daughter, with their child." On examining the house Dr. Watson found that the window had not been opened for a long time. In such an over-crowded, ill-ventilated space it is scarcely surprising that the disease soon spread to all the other inmates, though each one was sent without delay to the Edmonton Hospital. A short time ago the medical officer to the Whitechapel district gave some equally startling details. In several rooms in which dwelt a large family circle he found that night and day from forty to fifty chickens were kept, the stench from their ordure being simply frightful. In other houses he found rooms tenanted by happy broods of rabbits, and in one case upward of fifty pigeons, who fed and slept with the family renting the den, in the most delightful unsanitary harmony. Happily such scenes as these are daily becoming rarer and rarer. Zealous medical officers have succeeded in awaking some signs of enthusiasm even in parish authorities, and between the two it will be strange if the genius of disease has not a rough time of it.

The wretched dispute at Guy's Hospital still drags its slow length along, and will no doubt continue so to do for some time. The attention of Parliament, which meets early in the new year, will undoubtedly be called to the state of things existing there, and it is sincerely to be hoped a remedy will soon be found. At the very commencement of the quarrel the Times, in the course of a trenchant article on the subject, made some startling statements, and it is a significant fact that these still remain uncontradicted by the parties referred to in them. It was declared

that when one hundred and fifty beds had been closed for want of funds more than £3,000 had been expended on the treasurer's residence. Moreover, it was stated a very large sum had been laid out on the decoration of the chapel, and while the chaplain, a young and active man, had been pensioned off another had been appointed whose views were several degrees higher on the religious barometer. The residents of the district in which Guy's Hospital is situated have taken up the question very energetically, laymen as well as medicals, thus giving to the agitation a much greater prospect of success than if the movement had been of a purely professional character. The dispute stands now on a much broader basis than before, when it was simply a quarrel between the medical staff and the treasurer and matron. The question at issue is the entire system of government of Guy's, and indeed of other endowed hospitals. The other day a very largely attended meeting was held at Blackfriars, Mr. Cohen, M. P., being in the chair, supported by all the leading inhabitants of Lambeth and Southwark, and a number of important resolutions were passed with great unanimity and enthusiasm. It was pointed out that the government of the hospital was a self-appointed class government, responsible to no one, and most arbitrary in its proceedings; while the intention of the founder, Thomas Guy, that a large proportion of the governors should be made up from the medical staff was entirely ignored. It was finally resolved that a petition should be presented to Parliament, and supported by the borough members, praying for a searching inquiry into the abuses of the charity and a careful audit of the accounts. It is sincerely to be hoped, however, that what is termed a "royal commission" will not be appointed to inquire into the matter, for this is practically a constitutional method of politely burying the whole affair. A royal commission pursues its labors for two or three years, perhaps, before a definite result is arrived at. In the meantime a change of government may take place, when all the work already done has to be gone over again. However, the public meeting just mentioned has already borne fruit. The power of the treasurer

is greatly limited, being now controlled by the taking-in committee of governors, which includes two members of the medical staff deputed by their brethren. Let us hope that before long the strong hand of reform may be laid upon the entire system of management.

Some news has reached us from Scotland of importance to the whole medical profession. The prospect of a new medical college, of another source of medical diplomas, is of itself of sufficient interest, but in this case it will probably cause the downfall of an older foundation. Dr. John Baxter, a wealthy Dundee solicitor, has announced his intention of devoting £125,000 toward founding a college in that thriving town, merely making the condition that a satisfactory constitution be obtained, though he hopes the citizens will of their own liberality raise the sum of endowment to £250,000. Now the ancient University of St. Andrews is considerably under an hour's run by rail from Dundee, and the establishment of a new and busy college in that thriving city will probably give the *coup de grace* to the ancient university, which has never had a lusty existence, and which latterly has scarcely contrived to drag on life. Its income was chiefly derived from land, and the land not being let the university endeavored to do its own farming, with the usual fate of amateur agriculturists. Its future is gloomy in the extreme. While the universities of Glasgow, Edinburgh, and Aberdeen are overflowing with students and the professoriate growing rich with fees, St. Andrews has fallen into a siding which not a drop of the golden shower ever reaches. It is a little "lotus-eating" land where in time the most active professors get affected by the prevailing drowsiness. They work to obtain a chair in this charming sea-side town, seemingly so well suited to be the home of the scholar; but in time they work still more eagerly to get away. If they fail, as they usually do—for the courts of patronage know St. Andrews and its ways—they "eat of the enchanted stem," and, forgetting a world in which men write books and make researches, give up to the game of "golf" the mind that was made for mankind.

Nor, if all tales be true, is the Fifeshire University an academic Agapomene. With little to do, the professoriate do less, and, according to the old distich, idle hands always find some mischief to occupy them. It is to be admitted that some not altogether drugged with the prevailing somnolence heroically endeavor to occupy themselves with profit to the human race. They edit magazines, write poetry of their own or criticize the effusions of other bards, teach a dull world to fly, or devote their days and nights to conchology. But these are exceptions, regarded with disfavor by their colleagues. Rarely are all the professors on speaking terms, and very often some offending brother is being "pursued" for "slander" by an irate fellow senator. Thus the principal, who is reported to have declared that he never quite realized—well! Hades—until he had presided over the "Senatus Academicus" of St. Andrews, probably only spoke the sincere feelings of his heart.

The University of St. Andrews has, of course, a medical faculty, and grants degrees in medicine; but it has no medical school and no means of training medical students. Of the three members of the medical faculty, one teaches chemistry and mineralogy, and another is the titular professor of civil history, but, being a distinguished naturalist, lectures on rocks and animals instead of on wars and men. A college devoted to science and medicine could, however, be most suitably established at Dundee, where there is a large and well-equipped hospital. It would attract some of the many students who flock to Edinburgh and Glasgow, and would give new life to the decaying university, of which it might form an integral part. In fact, the new school might occupy the position in regard to St. Andrews University that the Newcastle medical school does to the University of Durham or the Gower Street College to the University of London. Under the new arrangement Edinburgh might be relieved of the overflow of medical students, who can not be properly taught in classes of three or four hundred. Moreover, with the influx of wealth St. Andrews might be induced to raise the standard of its doctorate, and not be tempted to confer its honorary degrees

on so many undistinguished celebrities willing to be taxed ten guineas for that dubious distinction. By the way, Sir Theodore Martin, the biographer of the Prince Consort, is the new lord rector of this academic Eden. He was elected toward the end of last month, obtaining an easy victory over his opponent, Mr. Freeman, the well-known historian.

The other day Frank Buckland passed away from us at the comparatively early age of fifty-four. Though few were aware of it, he was a medical man; indeed he was an old and very popular house-surgeon of St. George's Hospital. On leaving that school of medicine he entered the army and became an assistant surgeon in the Second Life Guards, but soon retired to devote himself to zoölogy and pisciculture. He had always shown the strongest fancy for natural history, from the curious and anecdotal side rather than from a scientific point of view. He was never weary of watching the ways of animals and their different modes of expressing their feelings. His house was a perfect menagerie, and his visitors were constantly amazed and startled by the strangeness of his pets. I remember an odd story he told of his going to Paddington Station to fetch a hamper about the contents of which he was very anxious. He got the hamper, and it was securely strapped to the back of his carriage. On the way home, however, some thieves cut the cords and bore away the prize, no doubt expecting to find wine or game. What must have been their expressions, verbal and facial, when they opened the hamper and found it full of live snakes! By the way, in 1859 Frank Buckland discovered in the vaults of St. Martin's Church, Charing Cross, the coffin of the great John Hunter, the founder of our splendid anatomical museum, and by his exertions it was removed to Westminster Abbey.

No doubt you are aware that a lively discussion has been for some time going on in Paris as to the abominable odors which pervade the gay city in every direction, and just now the "Poëles mobiles" or movable stoves are occupying the attention of the public. It is interesting that just at this time, when so much is being said in England in favor of these stoves, there

should be a decided movement toward giving them up in a country where they are most used. Dr. Angus Smith has been analyzing the gases issuing from one of these stoves in a room where the ventilation was imperfect, and he found that the proportion of carbonic oxide was sixteen times more than that emanating from a chimney. Only recently two young ladies who slept in the same room were found dead in their bed, nor could the accident be attributed to any other cause than asphyxia produced by the noxious gases given out from the stove in their bedroom.

I have just heard of a most extraordinary case of precocious menstruation occurring in the south of Spain. An infant of seven months was perceived by its parents to lose blood by the vagina. The blood flowed for three days, and then ceased. In the following month on the same day the flow returned, and lasted for a similar period; and thus periodically, up to the age of eighteen months, the child appeared to menstruate regularly. At that time the sanguineous flux was replaced by an abundant leucorrhea, which continued until January of the present year, the child being now three and a half years old. Since January the blood has reappeared and continues to return every month. The quantity of blood lost at each period is about an ounce and a half. This child is so well developed that at the age of three she appears like a little woman. The mammary glands are voluminous like little oranges, flexible and turgescent like those of a girl of sixteen, and with large areolæ and prominent nipples. The mons veneris is covered with hair. The intelligence of the child is not, however, as precocious as its physical development, the general behavior being quite puerile. This extraordinary story is given in the Medical Press and Circular. Verily truth is stranger than fiction.

But I must close, for the New Year has begun and I have much to do. Let me conclude by wishing you and your esteemed readers, if it be not too late, a happy and prosperous New Year.

Reviews.

A Practical Treatise on Nasal Catarrh. By BEVERLY JOHNSON, A.M., M.D. (Paris), Lecturer upon Clinical Medicine at the Bellevue Hospital Medical College, New York; Physician to St. Luke's and Charity Hospitals, etc. New York: Wm. Wood & Co. 1880. 8vo. Pp. 182.

It must be accounted progress in medical science to witness the publication of books on small sections of the field cultivated or at least traversed by the general medical practitioner, because such publication implies demand for special treatises, and a demand for them undoubtedly signalizes a closer attention to the various pathological conditions of the sundry apparatuses, organs, and tissues of the human system; and this is the soul of progress.

A London surgeon of eminence, but a very positive contemner of specialism, is reported to have said a few years since that he feared he should live to see a professional sign "John Smith, amputator of the left thigh"—a mot that was at once a measure of the surgeon's wit, his sarcasm, and his contempt for special surgery. Should he now have a congener among medical men proper, it would make the congener sneeze to find a treatise wholly on nasal catarrh; and yet, let it be repeated, such a treatise is the mark of progress, of valuable progress.

Apparently this book is written by one who gives his professional attention exclusively to nasal catarrh; and if so, he should acquire a much brighter knowledge and a much higher skill in this disease than others who do not thus devote themselves, just as the artisan who confines his labors to painting carriages shall exhibit a more esthetic taste in coloring and secure a richer finish than his brother workman who scatters his skill over the whole vehicle.

Specialism is a good thing, but it is not wholly good; and in

this it shares the heritage of all mundane affairs. A treatise on nasal catarrh prepared by competent head and heart may be of eminent service to the general practitioner, and not without value to other specialists. Dr. Robinson writes the anatomy, physiology, and pathology of the nasal passages, and roughly illustrates the anatomy by a woodcut. He pictures and describes the numerous instruments for examination and medication used by himself, and then presents a chapter on prophylaxis and treatment of coryza. Surely there is an apparent lack of a thoughtful consideration of the true physiological activity in some, certainly, of his prophylactic recommendations. "No healthy individual therefore should omit taking, in our climate, a cold sponge-bath upon rising each morning." This is confounding luxuries with necessaries. His injunction to maintain dry, warm feet to prevent coryza clearly ignores the influence of habit—an important factor in this and other affairs of dress and regimen; his demand that all persons in good health shall wear flannel next the skin throughout the summer to prevent a possible catarrhal affection of the nose is irrational and a bit of useless cruelty that no right-thinking man would inflict if he had the power; and his discussion of the warming of dwellings is *ad captandum* rather than *ex scientia*. Warming the ambient air by appropriate means neither fouls its nature, abstracts its oxygen, nor chars its motes.

He does not think any measure to abort a forming coryza can be relied on, but he recommends for trial teaspoonful doses of aromatic spirits of ammonia in an ounce or an ounce and a half of sweetened water every two hours for twelve doses, or

℞ Am. carb., ... } āā ʒj;
Liq. morph. sulph. (U. S.), . }
Mist. amygdal., ... ℥iij.

M. S. A teaspoonful in water (℥j – ℥jss) every hour during six hours, and afterward every hour and a half.

The patient would probably count the first a free administration of active medicine, and a doctor, unless he were a homeopathist, would most likely esteem the one hundred and ninety-second part of a grain of morphia in a teaspoonful of almond mixture

every hour for six hours not much of an aid to the two and a half grains carb. am., and both of them rather mild medication, and not apt to abort even an incipient acute coryza.

On page 146 the author says, "For quite a time I have given sulphur water from the white sulphur springs at Sharon," and an asterisk directs attention to a foot-note wherein he declares that "during the past two years I have not prescribed this water." Now, query, as the book has just been published, when was it written? It must have been more than two years ago. In a first edition why make a statement in the text and contradict it in the margin?

Notwithstanding the volume lacks the merit of a rigid scientific basis, evinces an *ex cathedra* manner of stating many practical conclusions rather than presenting them as the result of a close and discriminating clinical observation, and occasionally has the appearance that the author was more intent on making a book than on teaching the highest phase of unincumbered practical medicine; yet the treatise has a deal of good things in it, and will be found a valuable assistant to one who is already fairly grounded in medical science and consults it as an aid, recognizing that it is not a guide to be blindly followed in any of its chapters. J. F. H.

Treatise on Therapeutics. By A. Trousseau and H. Pidoux. Ninth edition, revised and enlarged. Translated by D. F. Lincoln, M.D. Vol. 3. New York: Wm. Wood & Co. 1880. Royal octavo. Pp. 362.

This volume completes the republication of this classical work, and places it among Wood's Library of Standard Medical Authors. With one or two exceptions we have praised the twenty odd volumes of this library, and we wish especially to commend the present work to the profession as worthy to be bought and thoroughly read.

Cutaneous and Venereal Memoranda. By HENRY G. PIFFARD, A.M., M.D., Professor of Dermatology, University of the City of New York, etc., and GEORGE HENRY FOX, A.M., M.D., Surgeon to the New York Dispensary, Lecturer on Diseases of the Skin, College of Physicians and Surgeons, New York, etc. Second edition. New York: William Wood & Co. 1880. 18mo. Pp. 309.

A priori one would suppose that diseases of the skin would be better understood and more successfully treated than those of any other tissue, because open to direct inspection and easily accessible for local medication. This supposition is, however, only seemingly true. One may find a papule on the skin, but of itself it does not declare whether it is a lesion of acne, eczema, lichen, prurigo, rubeola, scabies, strophulus, scrofula, syphilis, or variola. One sees only the elevated cuticle; what else is elevated, and how elevated, can not be established by inspection alone. To determine the causative pathological condition one must have knowledge as ample and thorough as is required to diagnose the morbid activity in a lung when one's ear detects a crepitant râle; perhaps even more so.

However this may be, it is safe to assert that the average doctor evinces more hesitancy in diagnosis and less assurance in treatment of cutaneous diseases than in any other general class of disorders of equal frequency and extent. Perhaps the charitable may find sufficient reasons to justify the condoning of this seeming ignorance in a large portion of the profession in the fact that it is but a short time since there was much confusion in the nosology, the etiology, the pathology, and the therapia of dermal disorders. Of a truth it is not yet all passed away, notwithstanding the valuable labors of acute and untiring investigators in every civilized country of the globe for many years. Within recent time, however, much valuable progress has been made in this behalf, and the authors of the volume before us appear to be fully posted in the latest advances, and have an excellent faculty for perspicuously stating the salient points to their readers. The book is too small to be more than a reminder of the more im-

portant conclusions reached by those who have made a special study of the departments of medical science it attempts to cover, but for this purpose the advanced student and busy practitioner will find it most instructive and satisfactory in both cutaneous disorders and venereal contaminations. J. F. H.

Ophthalmic and Otic Memoranda. By D. B. St. John Roosa, M.D., Professor of Ophthalmology in the University of the City of New York, etc., and Edward T. Ely, M.D., Assistant to the Chair of Ophthalmology, University of the City of New York, etc. Revised edition. New York: William Wood & Co. 1880. 18mo. Pp. 298.

This little book was originally issued in 1876, and its popularity appears to have called for several reprints, which were made without alteration in text or style. The volume under notice is named a revised edition, and the revision begins on the first page and runs through the book, ending with an appendix not in the original edition, all of the additions increasing the number of pages by thirty. Emendations are made not only by incorporating the advances in ophthalmology and otology that have taken place in the last few years, but the original text has in many places been rewritten with better words yielding a more lucid style.

The first edition was of signal service to the general practitioner at the time of its publication, and this revised edition will be equally so now to the same class, and possibly also it may not be without value to the specialist in the field it cultivates, for it is, as its authors aver, a kind of dictionary of ophthalmology and otology, a reminder and explainer in these departments, but is not intended to and can not take the place of treatises nor supersede text-books, and is without value to the neophyte in general medicine or any of its branches.

There is a sweet satisfaction for the doctor when he has a case

that is rebellious or puzzling in being able to pick up a book that will refresh him, in short space and concise words, of the points on which his memory has become a little obscure, and this is the service which this little volume will render him so far as ophthalmology and otology are concerned. J. F. H.

A Manual of Medical Jurisprudence. By ALFRED SWAINE TAYLOR, M.D., F.R.S., Fellow of the Royal College of Physicians; Honorary Member of the Medico-Legal Society of New York, of the Société de Médecine Légale of Paris, and of the Medical Society of Sweden; late Lecturer on Medical Jurisprudence and Chemistry in Guy's Hospital. Eighth American edition, from the tenth London edition, containing the author's latest notes made expressly for this edition. Edited, with additional notes and references, by JOHN J. REESE, M.D., Professor of Medical Jurisprudence and Toxicology in the University of Pennsylvania, Fellow of the College of Physicians of Philadelphia, Physician to St. Joseph's Hospital and to the Girard College for Orphans, Honorary Member of the New York Medico-Legal Society. With illustrations on wood. Philadelphia: Henry C. Lea's Son & Co. 1880. Large octavo. Pp. 933.

The preface to the American edition of this unequaled work opens with the mournful intelligence that its great author is no more. Dr. Taylor had, we are told, undertaken the revision of this edition expressly for the benefit of his American brethren, and had just completed it when he was summoned from the sphere of his earthly labors. A more complete work, a higher authority on all the subjects embraced within its scope, has not yet fallen from the press.

Clinic of the Month.

TREATMENT OF DIABETES MELLITUS.—Prof. Flint, in a recent clinical lecture on this subject, said:

The treatment is emphatically dietetic. There have been a great many remedies proposed from time to time, recommended as having control over this disease. Now I am not prepared to say that there are no remedies which do exercise more or less control over it. But we should commit a grave error, and act very much at the expense of the prospects of our patients, if we gave any remedy which rendered them less careful in attending to the dietetic treatment. In other words, the dietetic treatment is to hold the first place. This treatment consists in withholding from the food almost entirely (for entirely we can not) sugar in any form, and all the starchy constituents of diet capable of being transformed into sugar. That is the principle. Well, if we merely state that to patients, and tell them they must not eat sugar, they must not eat starch, they will not be likely to carry it out. In the first place, it is not likely they will know enough of the subject to be able to carry it out, even if they were so disposed; and unless we go further, and are very careful as regards details, we shall find that the elimination of these constituents of the food will not be done; they will not tolerate it. If we are to succeed we should give appropriate attention to the preparation of the food, the number of articles which the patient should be allowed to take, and the variation of the food from day to day, to make this anti-diabetic diet satisfactory to the patients; that is, satisfy their appetites and the purposes of nutrition. This can be done, and if it is done the patient carries out the treatment, because it is no hardship to carry it out; and the treatment is to be carried out not for a few days, or a few weeks, or a few months, but for an indefinite period—for years, and perhaps during the whole of life.

How is this second object to be effected? We must place before the patient a list of all articles of food which are to be avoided, specifying them; not contenting ourselves with the statement in general terms, but specifying on the one hand all the articles of food which he must not take, and on the other hand all the articles of food, animal and vegetable, and so on, which he may be allowed to take. He

should have such a list before him, and such articles should be selected from the allowable ones as to make a variety from day to day, and so prepared by the artifices of cookery as to render them satisfactory. It can be done, but it requires patience, and it requires care on the part of the patient or somebody else, and it requires some means. A very poor man, who has no one to look after these matters for him, and who has not sufficient means to obtain all the articles of food which are desirable, will find it very difficult to conquer this disease; and in certain public institutions—this hospital, for instance—it is very difficult to carry out the proper dietetic treatment. It requires so many things and so much attention to details that the dietetic treatment is very unsatisfactory in public hospitals.

The article of food which will cause most trouble is bread, and diabetics realize the force of the statement that bread is the staff of life. Frequently they say at first that they care little for bread, and can get along without it with no trouble; but they do not find it so after a while. They find that there is a craving for bread, and they feel that they can not do without it. So there have been various substitutes for it. There is what is called the diabetic flour, which is bran very finely ground so as to divest it of all rough particles; but it has no nutritive quality whatever. It is really no better than sawdust, so far as nutritive value is concerned, and the patient adheres to it only a short time. For the past two years the patients that I have seen have been in the habit of using a bread which so far seems to be very satisfactory, but it is not entirely divested of starch. It is what is called gluten bread, prepared by the Health Food Company, corner of Tenth Street and Fourth Avenue, of this city. Analysis shows that it is not entirely divested of starch, but it is so prepared that it is not deprived of the agreeable qualities of ordinary bread. Last winter I brought a loaf of that bread before the class and distributed it. I like it to eat myself, finding it by no means disagreeable; and patients take this bread and it meets their wants, thus removing a great obstacle to the successful dietetic treatment of this disease.

I do not deem it necessary to go over the entire list of these dietetic articles. You will find them by reference to different works. But the thing to do is to go into minute details with the patients. Explain to them fully just what is to be done.

Well now, after they enter upon this course of treatment in a very considerable proportion of cases the sugar diminishes at once, and sometimes it speedily disappears. Of course we should examine the urine from time to time to determine its condition as regards the presence of sugar and the amount of sugar. This treatment does not

cause a disappearance of the sugar in all cases. I have a patient under observation now whom I saw for the first time about three weeks ago—a young, thin, intelligent man, who, I have reason to believe, adopted the anti-diabetic treatment and has carried it out fully. I prescribed no medicine at first, and that has been my custom, in order to see what the dietetic treatment will do of itself. In this case it has accomplished very little so far; and this case I am led to fear therefore will be one in which we can not expect much success from treatment of any kind. If the dietetic treatment does not succeed we have no other resources; that is, no medicinal remedy yet known will succeed. It may have a certain influence over the disease, but it will not effect a cure. Then I could mention other cases. A gentleman whom I have seen now for two years, who until lately has taken scarcely any remedies, but has carried out the dietetic treatment very faithfully, presents urine which gives no evidence of sugar whatever. He retains his strength mentally and physically; he is a man of great activity, being engaged in business involving large responsibility, able to go on with it, and finding the dietetic treatment perfectly satisfactory—finding it no hardship.

Now, as to medicines, as I have said, a great number have been proposed from time to time, have been tried a short time, and then have passed out of use, others taking their place. This patient is not under my own care here. He is under treatment with the sulphide of calcium, a fifth of a grain three times a day, together with the dietetic treatment, so far as it can be carried out. With regard to this sulphide of calcium, one patient—a medical man in this vicinity who suffered from this disease—consulted me about three years ago, at which time he found that he had diabetes, adopted the dietetic treatment, relinquished his duties in town, which were exceedingly laborious, and went into the country, and his urine after a time showed no evidence of sugar. When I saw him last, which was a few months ago, I had never seen him look better, and he said to me that he had never felt better in his life. And, by the way, as an evidence that this disease may have existed some time before the patient's attention has been directed to any disease, this has been said to me over and over again by patients, even when the urine still contained sugar. They were not aware that they had any disease, as they felt much better than they had for months, perhaps for years before. They would not be aware that they had any disease were it not for a chemical examination of the urine. If they could put that out of view they would not have the consciousness of having any disease at all. This gentleman, who was a very able practitioner, was led to use the remedy that

I have just mentioned from finding it recommended, as he told me, in some medical journal. He has the impression that the sulphide of calcium had considerable to do with his apparent cure. Well, I am free to say that when I talked with him about it my own belief was that he was apparently cured by the dietetic treatment, and by a change of habits of life, the avoidance perhaps of some excesses.

To one patient who came to see me I stated these facts with regard to that remedy, and I said, "If you feel no objection I will prescribe it for you." This was a case in which the dietetic treatment had been extremely successful, and most of the time there was very little if any sugar in the urine. I told the patient that the remedy in question would do no harm; that I thought I could say that. He said, "Well, let us try it." I put him upon the remedy, beginning with small doses, and increasing them. I began in his case with an eighth of a grain, but I think we might begin with a quarter of a grain; in other cases I have begun with a quarter of a grain three times a day, after a fortnight doubling it, going up to two grains, and continuing it indefinitely. Well, this patient went on in that way, and he is very much impressed with the idea that it has been of use to him. Now we must make some degree of allowance with regard to the opinion of the patient as to the effect of the remedy. I do not mean to say that the remedy has not been of value, but I do not feel as certain as the patient does with respect to its value. I am also prescribing the same remedy in three or four other cases, but the period during which it has been used is too short, I think, to enable one to form a correct judgment with regard to it. I shall certainly continue the use of the remedy, for it can do no harm; and moreover, it is a gratifying thing to the patient to be taking a remedy which he supposes may be of use. The moral effect of remedies, as people's views are now, is by no means inconsiderable; it is a factor which we can not altogether ignore in the treatment of disease.

This disease I believe may be kept in abeyance indefinitely by appropriate dietetic treatment, and yet I am extremely doubtful whether a patient can ever properly consider that there is a permanent recovery.

Nitrate of Aluminum in Pruritus Vulvæ.—Nitrate of aluminum dissolved in five to ten parts of water has been used with success as a wash in pruritus. As this salt crystallizes with difficulty and is very deliquescent, it is best prepared *ex tempore* in form of a fifty-per-cent solution. 10.5 parts of dry aluminum

hydrate are dissolved by digestion with sixty-five parts of pure nitric acid, specific gravity 1.180, the solution diluted with water to one hundred and ten parts and filtered. The solution must be kept in glass-stoppered vials. Its specific gravity is 1.170–1.172. For each part of the crystallized salt two parts of this solution are to be taken. (*Pharm. Zeit.*)

TREATMENT OF DISEASED JOINTS.—Professor Verneuil lately read before the Société de Chirurgie de Paris an important paper on the immobilization and the mobilization of diseased joints, from which we extract the following:

Some urge that as the prolonged fixation of a joint may so alter its structure as to lead to anchylosis, therefore we must limit the fixation to the shortest possible time. Others maintain that rest, rigorous and persistent, is the best cure for an arthritis; therefore prolong the period of rest to the utmost extent, and disallow any attempt at movement. Bonnet, of Lyons, after having inclosed the diseased joints in immovable apparatus for a certain time, always took care, when the right moment seemed to have come, to commence passive movements, in order to restore suppleness to the joint.

This mixed practice seems nowadays to be almost universally adopted. Surgeons no doubt immobilize joints because they have found out that it is necessary, but they are always preoccupied by the supposed ill effects of prolonged fixation, and eagerly look out for the moment when they may recommence the movements *which are to prevent* anchylosis. Anchylosis, in fact, is a ghost which frightens not only the lay public, the patients, and their friends, but also nearly all general practitioners and not a few surgeons.

"In my practice and teaching for a long time past I have combated to the uttermost this idea of anchylosis and its prevention by passive movement. Perhaps my views may seem paradoxical; nevertheless I am led on to the discussion by facts. Thus a child with joint-disease was recently brought to me. I applied absolute fixation to the joint. All the pain ceased, swelling disappeared, and recovery was taking place. At the end of some weeks I was asked when it would be necessary to remove the bandages and commence movements. To this I replied that the time was not yet come Nevertheless in a short time the general practitioner, probably urged on by the friends, removed all the apparatus. As a consequence, the benefits then gained were lost, and the lesion progressed. The child was again brought.

Some excuses were made. I again ordered fixation, and the child is now in a fair way to recovery."

The facts invoked against fixation are indeed very few, and only moderately conclusive. If the accusation is true we ought to be surprised that the proofs are so uncommon. To discuss the subject with advantage we must at least distinguish between healthy and diseased joints, and among the latter we must further establish varieties. First then as regards healthy joints. I affirm that there does not exist a single fact which shows conclusively that fixation, however long continued, has ever led to anchylosis. This long-continued fixation may, it is true, give rise to anatomical modifications such as diminution in the extent of the articular surfaces to a thinning of their lining cartilage, also to a reduction in size of the synovial sacs to a less abundant synovial secretion, and to functional changes such as stiffness of the joints and limitation of movements. Hence, not unnaturally, when the necessity of immobilization has ceased, a certain time will be required for the complete restitution of the articular function. But there is nothing in all this which at all resembles anchylosis. It is only comparable with what takes place in mucous glands which are no longer traversed either by ingesta or by excretions. They do not become obliterated, as was taught by Bichat, but simply reduced in size. Their healthy condition, however, is again established in a few weeks, or, at most, a few months, when their function is once more revived. What better example could one have than the bladder in the case of a vesico-vaginal fistula? It becomes reduced to a mere pouch, but again resumes its normal capacity as soon as the fistula is closed. I am well aware that every where autopsies and experiments on animals are quoted, but neither one nor the other have completely convinced me. I could show that the various lesions which are revealed are not in any way of the nature to lead to anchylosis, but can be attributed to other causes rather than to the fixation. On the other hand, I might mention the numberless examples of well-known cases in which the joint, for a long time kept immovably fixed, has notwithstanding retained its structure and rapidly resumed its functions when permitted to do so. These latter facts are at least as numerous as the opposite ones, and, being more simple, are also more convincing. It is clear either that fixation *alone* suffices to alter a joint (and then it ought always to do so), or there is need of a peculiar predisposition and a suitably prepared soil, in which latter case it behooves us to seek whether this predisposition does not play the principal rôle. The learned professor inclines to this latter view. He admits that at the termination of any arthritis, in the treatment of which fixation more or less prolonged has

been made use of, there is a diminution, a suspension, or even an abolition of movement, but does not see why this functional suppression should be attributed to fixation rather than to other causes, especially the anatomical lesions present in the joint.

Prolonged fixation incontestably modifies healthy joints, but not profoundly, either in form or in the structure of their constituent parts, or as regards their ultimate function.

There does not exist in scientific records any authenticated examples of anchylosis produced in a healthy joint by mere fixation. The cases hitherto advanced in support of such an idea are capable of another interpretation. On the other hand, there are on record numerous examples of joints which have been kept immovable for long periods and have regained their anatomical and physiological integrity.

Inflammation no doubt occupies a first place among the causes, and as it is absolutely proved that fixation is an antiphlogistic of the first rank it is illogical to think that it produces those effects which it is known to cure.

If in certain cases fixation continues to produce anchylosis it is not that fixation which the surgeon secures by apparatus, but rather that which is due to the contracture of the peri-articular muscles. As much as the latter, which may be called *active*, favors and indeed provokes articular disorder, by so much the former, which is *passive*, is powerful against them. There is therefore a capital distinction to make between the two varieties of fixation.

Anchylosis, on the other hand, far from being produced in articular disease, is but a rare termination to it. Exceptional in strumous arthropathies, a little more frequent in rheumatic mono-synovitis, it is especially to be feared in suppurative and traumatic arthritis, though no one variety of disease is certain to produce it.

The exaggerated fear, therefore, of ancholysis has caused many practitioners to make grave errors, and has frequently led to the too early leaving off of passive fixation and the too premature recommencement of movement.

Mobilization consequent on joint-disease is of two kinds—artificial or mechanical, and natural or physiological—brought about by muscles, either voluntary or otherwise. The former, which anchylophobes use exclusively, is admissible when we have to deal with the rectification of vicious attitudes of limbs and to treat confirmed anchyloses, but it ought to be rejected as useless, powerless, and dangerous if we would avoid anchylosis. The latter, on the contrary, is of extreme utility if applied at an opportune moment. With time it accomplishes in a remarkable degree the restoration of the articular function.

He concludes by saying that artificial fixation on the one hand and natural fixation on the other are the two principal therapeutic agents in arthropathies. The one combats anatomical lesions; the other restores physiological action. We may assist the former by different means—local, pharmaceutic, or hygienic; we favor the second by electrization of the peri-articular muscles, practiced during the period of fixation with a view to the prevention of degenerescence.

To combat the inflammation is the best means to prevent anchylosis. As regards surgical measures proper, I know of none better than continued extension, and in extreme cases preventive resection. (Medical Times and Gazette.)

Sulphate of Copper for the Eruption Caused by Rhus Toxicodendron, Rhus Radicans, etc.—Dr. A. W. Wiseman writes, in the Virginia Medical Monthly, that for this eruption he uses but one remedy, and has had less trouble with it than with skin-diseases generally. It is the sulphate of copper. It may fail in some acute cases. He has no particular strength for the solution. He commences with just enough to color the solution, and gradually increases the strength until it produces a slight stinging, and applies it three or four times a day.

Treatment of Infantile Diarrhea by Powdered Charcoal. Dr. Guérin says that for a long time he has been in the habit of combating infantile diarrhea by mixing the milk in the sucking-bottle with charcoal powder. He usually adds half a teaspoonful of the powder to one bottle of the milk. The infants take the milk readily, and in a few days the greenish stools of the little patients change to a dark yellow, while their consistence becomes increased. In addition to the admixture of powdered charcoal, the milk is diluted by one half or one third of its bulk of sugared water. He has frequently seen intractable summer-complaints yield in a few days to this treatment. (Medical Record.)

Bokkenheuser on Salicylic Acid in Acute Articular Rheumatism.—Dr. Bokkenheuser, of Copenhagen, concludes from a careful observation of eighty-one cases of acute articular rheumatism, treated with salicylic acid, that by this method the

number of acute cardiac affections occurring in the course of the disease may be markedly diminished, and that it is epecially useful in preventing an attack of pleurisy. He found also that salicylic acid was very useful in suppressing articular affections due to exacerbations of a chronic articular rheumatism. On the contrary, he found the drug of no avail in simple non-rheumatic arthritis or in attacks affecting a single joint. (New York Med. Journal.)

Treatment of Typhoid Fever.—The debate on the treatment of typhoid fever, at the Metropolitan Counties Branch of the British Medical Association, was opened by Dr. Bristowe, who dealt with the subject under the heads of food, medicines, alcohol, and baths. A milk diet was urged as of chief importance. Dr. Bristowe doubted if any remedies had direct effect in controlling hemorrhage. Alcohol was not necessary, except in a few cases, when it should be given for its stimulant effect. As to baths, he doubted their efficacy, and thought if they were as valuable as statistics showed their good effects should be obvious whenever they were tried. In two cases he had had he thought fatal pulmonary congestion had been produced by the use of baths. He concluded his remarks by sketching the manner in which he himself would wish to be treated were he the subject of the fever.

Dr. Broadbent, who followed, thought the diet should not be wholly restricted to milk, which it was important to give only as food, and not as a drink to relieve thirst; for diarrhea was often produced by the undigested curds. Sometimes beef tea set up diarrhea. Besides correcting the diet when diarrhea was present, he would use opium enemata. In cases of hemorrhage he gives large doses of opium to arrest peristalsis. Ergot and turpentine were also useful. Opium was also of great value in the relief of tympanites. He described his attitude toward baths as one of gradually increasing confidence.

Dr. Cayley read a letter from Dr. Brand, of Stettin, giving some remarkable statistics from the military hospitals of Ger-

many in favor of the bath treatment—a chief element in success being the adoption of the method at the very onset of the disease. This was possible in private practice and in military hospitals, but not in the civil hospitals, where patients do not seek admission until they are compelled to do so by the advance of the disease. In Germany it had been found possible to carry out the bath treatment in private practice. The treatment was certainly *not* a dangerous one.

Dr. Norman Kerr made some remarks, in which he admitted the need of the medicinal use of alcohol in some cases of the disease.

Dr. Collie said that out of a hundred cases seventy-five would get well with simply good nursing, fifteen would die, and the remaining ten might or might not recover. Such was his experience, and he had abandoned the bath treatment as not only useless but even dangerous. He could not put faith in continental statistics, and thought that many cases of mistaken diagnosis were included in them.

Dr. Ord had certainly seen good effects from the use not of cold but of slightly tepid baths in selected cases of high pyrexia, which he believed had a relative effect as well as a control over the whole morbid process of typhoid fever.

Dr. Mahomed spoke in favor of the cold-bath treatment. He also mentioned a case of severe hemorrhage which he had recently successfully treated by transfusion. (London Lancet.)

The Extirpation of the Uterus after the Method of Freund. — Dr. Rydygier narrates (*Berliner Klinische Wochenschrift*, No. 45, 1880) a case in which he performed this operation for cancer of the uterus. The patient died the next day. Dr. Rydygier makes some remarks on the details of the operation. He regards it neither as one very easy of performance nor as being extremely difficult. Before opening the abdomen he inserted a speculum into the vagina, and cut through the vaginal mucous membrane all round near its attachment to the uterus. By this modification he claims that the length of time

the peritoneum is exposed is lessened; that the vaginal insertion is cut through more easily in this way than from above; that there is less risk, when it is divided thus, of wounding bladder or rectum; and that the incision made in this way can be more accurately executed so as to include all the diseased part. This part of the operation he performs in a different room from that in which the abdominal incision is made, and between the two parts he thoroughly cleanses and disinfects his hands. He does not use the three ligatures recommended by Freund, for he says they can not always be tied tight enough to surely prevent hemorrhage, and sometimes one of them includes the ureter. He ties the uterine artery separately, and says there is no difficulty in doing so. He believes that these modifications make the operation both more easy and less dangerous. (Med. Times and Gaz.)

Tracheotomy in Infants.—It is well known that tracheotomy, for whatever reason it be undertaken, is always more fatal in early infancy than in more advanced years. One of the youngest of the successful cases on record is interesting, not only on account of the age, but also because the operator was the father of the little patient. We refer to the well-known case in which M. Scoutetten, of Strasburg, in 1830, successfully operated on his own infant, aged six weeks. Some doubts have been expressed as to the nature of the disease which called for the operation. We will not stay to discuss the matter, contenting ourselves with the moral that there is nothing in the operation itself incompatible with recovery even at the age of six weeks.

Since this date some other cases of early tracheotomy have been recorded: Mr. Joseph Bell, of Edinburgh, reported a successful case at six months and a half; Mr. Tait, at seven months; Dr. Greenfield, at ten months; Mr. Cooper Forster, at eleven months. There are doubtless many other cases, if we could collect them, of successful operation in very young subjects. The recollection of them will help to reconcile those who have hitherto abstained from operating simply on the ground o youth.

Another successful case in a very young infant (aged nine weeks) is recorded in the *Berliner Klinische Wochenschrift*, No. 40, 1880. Dr. H. Steinmeyer, of Brunswick, was sent for to see an infant who was said "to be ill with diphtheria and choking." The child came of a phthisical mother. It was normally developed, and during the first four weeks of its life had always been quite healthy. In the fifth week it had had abscesses near the anus, and others on the palms of its hands. The infant wasted considerably during this time. In the eighth week a cough had come on, and it daily became worse and emaciated, and difficulty in breathing set in. This latter symptom persisted, and on its becoming very urgent Dr. Steinmeyer was sent for. When first seen the usual symptoms of laryngeal stenosis were very manifest; viz. cyanosis, with drawing down of the facial muscles during inspiration, which was loud and hoarse. Expiration was short and inaudible. There was great retraction in the epigastric region. Nothing abnormal, beyond oidion albicans, could be detected in the mouth or pharynx. The epiglottis, when examined by the finger, did not appear to be sufficiently swollen to be the cause of the obstruction. A laryngoscopic examination could not be satisfactorily made. On the exterior surface of the neck, over the right thyroid cartilage, and in size corresponding with it, a very slight swelling was detected. It was only appreciable to the eye by carefully comparing the two sides. It did not fluctuate. The temperature was 103° F. (39.5° C.), and the pulse could not be counted. Tracheotomy was decided upon. But the exact cause of this obstruction could not be made out, although an abscess in the neighborhood of the larynx was suspected. The operation was a very difficult one, and lasted an hour. The trachea was no larger than a goose-quill. It was displaced considerably to the left of the median line. An anesthetic does not appear to have been used. The operator, "on account of the infant's restlessness, found great difficulty in introducing the canula. Respiratory trouble ceased immediately on opening the trachea, all cyanosis quickly disappeared, and the infant rapidly recovered. It could not, however, take the breast

on account of coughing. It rested well all the next night. Four days after the operation, the temperature still being 103° F., the child became very restless. The swelling over the thyroid cartilage was more manifest, and the superimposed skin somewhat reddened. An incision into it through the tracheal wound let out pus, and on enlarging the opening on a director a very considerable amount of pus was evacuated. The cough continued troublesome. Attempts to remove the canula were unsuccessful. The temperature was normal. After the tenth day the child, which up to this time had continued to improve, began to get worse. Its food (milk) regurgitated through the nose. There was nothing appreciable to account for this unfavorable change. On the thirteenth day after the operation, however, suddenly, and while the child was trying to scream, a quantity of fetid pus was discharged through the mouth, while some more issued from the tracheal wound. Very shortly after this the child began to cry audibly. The canula was removed on the following day, and complete recovery was very soon established.

It will be obvious that the case was one of retro-pharyngeal abscess. The diagnosis is often quite impossible, and under the circumstances tracheotomy appears to have been the only resource. We congratulate the operator on his successful case. (Medical Times and Gazette.)

Management of the Third Stage of Labor. — Dr. Max Runge, in a communication to the Obstetrical Society of Berlin, criticizes the current teaching regarding the management of the third stage of labor. He takes as the special text of his animadversions the directions given by Fritsch, which are to the effect that *immediately* after the birth of the child the uterus is to be seized by the hand on the abdomen, and the placenta pressed out. Dr. Runge states that for a long time he faithfully carried out this method; and so did others in Prof. Gusserow's clinique. The objection to it is, that the squeezing out of the placenta is begun before that organ has become completely separated; consequently, when the placenta has been expelled, often

a bit of the membranes may yet be attached to the uterus and be left behind after the placenta has been taken away. While this teaching was carried out it was quite a common thing for a pair of forceps to be needed to remove these retained pieces of membrane, and secondary post-partum hemorrhage became extraordinarily frequent. He refers to a former communication of his own, in which, treating of post-partum hemorrhage, he expressed his surprise that within a short time he had had many cases of this complication. Then he supposed this frequency was fortuitous. Now he knew the reason, which was his undue haste in pressing out the placenta. Midwives are now instructed, after the birth of the child (and having, of course, seen that the uterus is sufficiently contracted upon the placenta to prevent hemorrhage), to wash and dress the infant before proceeding to press out the placenta. The separation of the placenta and membranes, Dr. Runge holds, is not complete until, upon an average, about a quarter of an hour after the birth of the child; and therefore about this length of time should be allowed to elapse before the placenta is pressed out. Since instructions based upon this principle have been given to the students and midwives of the Strasburg Obstetric Clinique post-partum hemorrhage has become of very infrequent occurrence. (Journal of Psychological Medicine.)

PALATABLE QUININE.—Dr. Dodson writes in the Maryland Medical Journal that the unpleasant taste of quinine is largely ameliorated by giving it with Liebig's liquid extract of beef; that he has been able to administer it in this way in cases where otherwise it was impracticable; that this preparation of beef, given before taking the quinine, appears to have a tendency toward preparing the stomach for its reception.

ESMARCH'S POWDER.—The so-called painless caustic powder of Esmarch is prepared as follows: Arsenious acid, one part; morphia sulphate, one part; calomel, eight parts; pulv. gum arabic, forty-eight parts; mix.

ON THE RADICAL TREATMENT OF HERNIA WITH THE AID OF CATGUT AND LISTERIAN ANTISEPTICS.—Thomas Annandale, Regius Professor of Clinical Surgery in the University of Edinburgh, says, in Edinburgh Medical and Surgical Journal:

The operation which I advocate and practice is to expose the neck and upper portion of the sac by a free incision, to make a small opening into the sac, to carefully return the contents, and in the case of adherent omentum or intestine to ligature and divide adhesions, to separate the sac from its attachments to surrounding textures, to draw down the sac and apply a catgut ligature around its neck as high up as possible, to cut away the sac immediately below the ligature, and then to stitch together with a continuous catgut suture the margins of the abdominal opening, the stump of the ligatured neck, and the surrounding cellular tissue. The whole operation and the after-treatment are performed under strict Listerian antiseptic principles. One advantage of this method is that it is applicable, with perhaps some little modification, to all the varieties and all the conditions of hernia, with very few exceptions. The risk of this operation, if carefully performed, I believe to be slight; for it would appear that a hernial sac, unless of very recent origin, is not by any means sensitive to serious inflammatory action, and it can therefore be handled and operated upon with wonderfully little risk. I will now refer to the classes of cases in which the operation may be used.

1. In cases of strangulated hernia.

In 1872 I operated on Mrs. M., aged seventy, for strangulated femoral hernia. On opening the sac a knuckle of congested gut was found, and a large piece of omentum, the latter being firmly adherent to the sac. Having divided the stricture, I ligatured the omentum with catgut, cut it across, and returned the intestine and ligatured stump of omentum into the abdomen. I then separated the sac from the surrounding textures, drew it down, and, having applied a catgut ligature around its neck, cut away the sac and adherent omentum. The result was most satisfactory, and pleased me so much that since then it has been my practice, in all cases of strangulated hernia in which the gut was in a proper state to be returned, and in which a distinct sac existed, to adopt this proceeding; but during the last two years I have, in addition, stitched the margins of the abdominal opening together in the way already described. In illustration I relate the following case:

Miss L., aged thirty-two, seen in January last. She had suffered from an irreducible femoral hernia for three years, and on the morn-

ing of the day I visited her she was seized with symptoms of strangulation shortly after straining herself in lifting some heavy books. The usual operation for strangulated hernia was performed, and on opening the sac it was found to contain a large knuckle of gut and a portion of adherent omentum. Having divided the stricture and ligatured and cut across the omentum, the gut was returned, the neck of the sac ligatured, the sac and adherent omentum cut away, and the stump of the ligatured sac carefully stitched to Poupart's ligament and the surrounding tissues. She made an excellent recovery, and now is able to go about with perfect comfort, but wears a light truss as a matter of precaution.

I could relate other cases of a similar nature, but it is unnecessary. This addition to the ordinary operation for strangulated hernia does not in any way add to the risk of the operation; and I can say from experience that it is not only an assistance in preventing descent of the hernia during the healing of the wound, but it is also a valuable means of diminishing the risk of the hernia returning in the future.

2. In permanently irreducible hernia.

The risks connected with hernia of this kind and the difficulty of treating such cases have been experienced by all practical surgeons. At any time the condition of strangulation may result, and the risk is increased owing to the difficulty of effectually applying a truss or bandage so as to prevent a further descent of the abdominal contents. The operation advocated in this paper is perhaps of more value in this class of case than in any other, and I offer a few cases in illustration.

Case I. Mrs. C., aged fifty, suffering from a large irreducible femoral hernia the size of an infant's head. A swelling was first noticed in the region of the hernia five years before, and until eighteen months ago was reducible. Since then it has been irreducible, and during the last few months has given her so much inconvenience that she required to lie almost constantly on her back. The operation already described was performed, and as a large mass of omentum was adherent to the sac it was ligatured and cut away. She was dismissed cured and wearing a light truss fourteen days after.

Case II. Mrs. ——, aged about forty, the wife of an esteemed medical friend, was brought to me by her husband a few months ago on account of an irreducible femoral hernia. She had noticed a swelling in the femoral region for six years, but it gave her no trouble until August last, when it became suddenly larger and caused pain and sickness, which passed away after resting and pushing back a portion of the tumor into her abdomen. Shortly after this the swelling again increased suddenly and gave rise to similar symptoms, which, how-

ever, passed off when treated as before. An examination of the swelling and a consideration of the history of the case caused me to diagnose it to be one of irreducible femoral hernia, the result of adherent omentum, and I advised operation to prevent the risk of strangulation. Her husband, being naturally anxious as to the question of operative interference, asked Dr. M. Duncan, who was in Scotland at the time, to meet me in consultation, as he had previously attended my patient. Dr. Duncan agreed with me as to the advisability of the operation, which was performed in the usual way on the 6th of October. A large piece of adherent omentum was present in the sac, and it was ligatured and cut away along with the sac. In less than two weeks the wound was quite healed. A few days after a light truss was applied, and the patient returned home within three weeks after the operation.

Case III. J. R., aged forty-four, admitted June 15, 1880. Two years and a half before admission the patient strained himself, and after this a swelling gradually appeared in the left groin and passed down into the scrotum. It was never perfectly reducible, and the patient, being unable to wear a truss, could not follow his employment, which was that of a miner. When examined there was found in the left side of the scrotum a swelling the size of a child's head. This swelling had a distinct neck passing up into the abdomen, but only slight impulse was obtained when the patient coughed. The corresponding testicle lay on the anterior aspect of the tumor, and the tumor itself was somewhat lobulated, and felt like a fatty growth. The patient, being anxious to obtain relief, requested me to operate, and accordingly I made a free incision over the neck and upper part of the hernia, and in doing so exposed the testicle and cord, the constituents of the latter being spread over the tumor. The testicle and the constituents of the cord being held away, a very thin sac was exposed, and on cutting into it a large mass of adherent omentum appeared. On tearing this aside a portion of the large gut, with fatty processes attached showed itself, and on examination this contained gut was found to be the sigmoid flexure of the colon and a portion of the descending colon. Further examination determined that there was no true sac on the posterior aspect, but the large intestine, uncovered by peritoneum, formed the posterior wall of the tumor. With time and care the adherent omentum and the adhesions of the gut to the tissues behind were ligatured and divided, the whole contained gut was returned, and the remnants of the sac were drawn down, ligatured, and cut off, and the margins of the abdominal opening stitched together in the usual way. One month after the operation the wound was

healed and a light truss applied. The patient returned home well on the 19th of July.

Prof. A. details two other successful cases, and then adds:

I must now refer to the only fatal case which has occurred in my practice. At the beginning of last year I met the case of Mr. S., aged fifty. For many years he had suffered from a scrotal hernia on the right side, which gradually increased in size until it formed a swelling which reached nearly to his knee. For two years it had been irreducible, and as he could wear no truss or bandage his life had become miserable to him, and he was anxious to obtain relief by operation or by any other means. On the 22d of April of the same year I exposed by incision the neck and upper part of the sac, and without opening the sac endeavored, but without success, to return its contents into the abdomen. Finding that the contents of the hernia were adherent to the sac, I opened the sac, and discovered that a large piece of adherent omentum was the cause of the irreducibility. When the sac was opened a large quantity of the small intestine escaped, and it was with some difficulty that this gut was returned. The adherent omentum being ligatured, and the contents of the sac, which consisted of nearly the whole small intestine and a large quantity of omentum, having been returned, the neck of the sac was ligatured, the sac cut away and stitched to the margin of the external ring in the usual way. For three days the patient progressed favorably, but after this symptoms of intestinal obstruction showed themselves, and he died two days after. My opinion is that some twisting of the gut took place and caused the fatal result. I attribute the non-success of this case principally to the large size of the hernia and to the protrusion and return of so much of the small intestine—a proceeding likely to lead to some malposition of the gut.

These cases, together with others of a similar nature which have come under my observation, are, I venture to think, an encouragement to treat by operation permanently irreducible herniæ when the patient's condition admits of such a proceeding.

3. In reducible hernia.

I am no advocate for operative interference in cases of reducible hernia unless the condition is irrelievable by the application of a truss or other means, and is giving rise to serious inconvenience. When operative treatment is required in these cases I am inclined to advise the adoption of the proceeding of which this paper treats. This proceeding has certainly the one important advantage that the surgeon

sees what he is doing, and I have not found that the free exposure and handling of the parts is attended with any special risk.

The author then reports a few cases, and concludes:

I do not say that these cases which I have related are necessarily permanent radical cures, but I feel confident that the operations performed relieved them of a condition otherwise incurable, and permitted the patients to wear with success a truss and to go about and follow their employment without risk. Whether the operation is inferior or superior to Wood's method of radical cure in cases of reducible hernia, I am not prepared to say, as further experience of the results of the former operation is required; but it certainly has the one advantage that it is applicable, as I have already mentioned and I hope proved in this paper, to all herniæ and to their various conditions, with very few exceptions.

BLADDER-DRAINAGE.—Mr. John Chiene, Surgeon to Edinburgh Royal Infirmary, recently read before the Medico-Chirurgical Society of Edinburgh a paper on this subject, from which we make the following abstract:

In August, 1876, a case of perineal fistula was admitted into the clinical wards in the Royal Infirmary. A large opening, the result of sloughing, had formed in the floor of the urethra behind the scrotum, through which all the urine passed at each act of micturition. It was evident that a plastic operation was necessary. From previous experience in such cases the great delay in the healing seemed to me to be due to the difficulty experienced in keeping the wound dry. If a catheter is tied in the usual way, and a plug worn, which the patient removes at each call to micturate, the result is, that on the day following the operation, during micturition, the urine passing along the sides of the catheter reaches the wound and interferes with or altogether prevents union. Even if no plug is used, the urine being allowed to drip into a basin between the patient's legs, the same result follows, to say nothing of the damp, uncomfortable condition of the bed.

The problem seemed to be, How can the wound be kept dry for some time, and thus placed in favorable conditions for healing? The method adopted after various experiments and trials was as follows: A gum-elastic catheter is introduced and fixed to the penis with sticking plaster. Care is taken that the eye of the instrument is just within the neck of the bladder. To this catheter an india-rubber tube is

fixed, of sufficient length to reach without being strained over the side of the bed to the floor. It then passes into a bottle. The bottle and tube are filled with carbolized water before attaching the apparatus to the catheter. Care is taken that no air can get in at any of the joints. It is well to introduce a piece of glass-tubing at a convenient part for observing the direction of the flow. In order to keep the india-rubber tube steady in the bottle, a piece of glass-tubing is attached to its extremity. If the glass-tube extends beyond the neck of the bottle, any folding of the india-rubber tube at this point will be prevented. It will be evident that a siphon action is in this way established, with a suction power the strength of which depends on the height of the column of water, and which will draw the urine into the eye of the catheter as it passes drop by drop from the openings of the ureters into the bladder, and a constant slow current of water will pass along the tube into the bottle. The bottle is allowed to overflow into a basin, which as it fills can be emptied by the nurse without any risk of displacing the apparatus. The bladder is kept constantly empty, with the exception of two tiny streams of urine from the ureters to the eye of the catheter. Care must be taken not to have too great a fall, or the suction of a piece of mucous membrane into the eye of the catheter will cause uneasiness and plug the catheter. The height of the hospital bed is generally sufficient, and in some cases even a less height is all that is required.

It will be evident to the experimental therapeutist who may desire to study the action of diuretics that by this apparatus much will be learned. The bottle being graduated, the rapidity of action can be easily studied. Since using the instrument on the human subject I have learned that Professor Goltz, of Strasbourg, has used a similar apparatus in an experimental research requiring an accurate estimate of the exact amount of urine secreted in a given time. In the first case the apparatus did not act perfectly, and on the sixth day the wound became wet with urine. The result was only an improvement. Still the success was so marked that I tried it in the following year in another case in which the flow of the urethra was destroyed for an inch and a half by injury. The result in this case was a complete success. After the plastic operation the apparatus was applied, and the wound kept perfectly dry until it was soundly healed.

Since 1877 this method has been used in a case of recto-urethral fistula with much advantage; in 1879 in four cases of chronic persistent perineal fistulæ which had resisted the usual means of treatment. In three of these cases a stricture, in the fourth a perineal abscess, the result of cold, started the condition. In all a permanent cure resulted.

In these cases the instrument was kept in continuously for periods varying from a week to a fortnight. It was occasionally removed in order to readjust it. During the time it was removed for cleaning, the patient was instructed not to make his water. I have never found any bad results whatever follow its use. It is also of value in hastening healing and keeping the patient dry and comfortable during the healing of the wound after external division of a stricture.

Let me, however, more particularly direct attention to bladder-drainage in chronic cystitis. It will, I think, take a most important place in the treatment of that troublesome and common affection. The two great symptoms are frequency of micturition ("irritable bladder") and excessive quantities of mucus in the urine ("catarrh of the bladder"). The first symptom is at once relieved by the use of the instrument, and in some cases its use even only during the night gives the patient unspeakable comfort; but in the majority of cases it is best kept in the bladder continuously. The difficulty is the choking of the instrument with mucus. This will be prevented by having a double eye in the catheter, and by raising the bottle night and morning in order to make a back flow, which clears the instrument. The patient can very soon tell when the flow ceases, and the bottle can then be raised slightly above the level of the patient. At once the plug of mucus is displaced. It is very interesting to observe the effect of rest to the bladder as indicated by the decrease in the quantity of mucus. In one case of perineal fistula complicated with chronic cystitis this improvement was very marked. The systole and diastole of the bladder are excessively increased in irritable bladder. No heart would stand such an increase in its pulsations. This, in my opinion, is one of the reasons why chronic cystitis is so intractable; and any means by which we can prevent the periodic rise and fall of the bladder, the incessant unrest of the organ, will always be of the greatest value in relieving inflammation of the viscus. For its value in chronic cystitis alone I would be inclined to recommend a careful trial of bladder-drainage. By some means or other let it be carried out; the method matters not. What is important is to come to a conclusion as to the value of the principle involved. Its main value in chronic cystitis, in my opinion, is to give the bladder rest. It acts as a drainage-tube in a wound or in an abscess cavity. It has, however, a value in urethral fistulæ; in those requiring plastic operations it keeps the wound dry and allows speedy union to take place; in those requiring only that the urine which is abnormally passing along the fistulæ and keeping them open should be prevented from so doing by being drained off immediately on its entrance into the bladder. *To give the bladder rest*

and *to keep the urethra dry*, I know no better means than that which I now advocate. I am not aware that the idea of keeping up a constant suction-power which draws off the urine as it drops into the bladder has been previously recommended in surgical practice. It is certainly a very different thing from the use of the catheter tied in and used in the ordinary way. That the means recommended are simple, is self-evident; they can be applied by any one. That no harm is done to the patient, is the result of my experience; that all operations on the urethra are treated more certainly by the use of the apparatus, and that it is of great use in many cases of chronic cystitis, relieving the symptoms in all and giving permanent relief in others. That the symptoms of chronic catarrh are in some cases very intractable, is evident when we remember that chronic cystitis has been treated by the lithotomy incision in order simply to rest the bladder.

In the discussion which followed the reading of the paper several points were raised to which it may be well to allude:

1. Its use in catarrh of the female bladder. I have tried it, but found the siphon did not work. I believe in consequence of the short urethra air passed into the bladder and destroyed the siphon action.

2. The use of the red rubber catheter instead of the gum-elastic instrument. The red rubber catheter is not so easily fixed in position.

3. Its use in enlarged prostate and malignant disease of the prostate. I have not used it in these diseases. In one case of enlarged prostate I tried it, but it did not work efficiently. It might, however, be of use. For my own part, since Mr. Jonathan Hutchinson directed my attention to the value of the red rubber catheter for drawing off the urine in prostatic cases the disease has been robbed of many of its terrors.

4. The danger of phosphatic deposit on the point of the catheter. This has never given me trouble. I suspect the reason is that the point of the instrument is not lying in urine, but is practically dry, the urine being drawn off into the eye of the instrument by the suction power, to which I believe the value of the instrument is to be attributed.

5. I have never had occasion to use it in rupture of the membranous urethra. In such a case I should most certainly try it. It would be of great assistance in preventing extravasation of urine.

6. The habitual night and morning raising of the bottle is, in the majority of cases of chronic cystitis, sufficient to keep the catheter clear of mucus and prevent plugging of the instrument.

7. How the catheter should be fixed to the penis. In tying in a flexible catheter, which adapts itself to the curves of the urethra, the best way, in my experience, is to affix a strip of sticking-plaster to the

catheter firmly with silk. This strip passes down either side of the penis. A piece of boracic lint is wound around the catheter at the meatus urinarius under the strip of sticking-plaster. Another strip of sticking-plaster is wound around the penis over the strip passing down the sides of the organ. After it has been around twice, the strip passing along the sides of the organ is turned back toward the point of the penis, and then two more turns are applied over it. It is then turned down again, and two more turns are applied. In this way the catheter is practically incorporated with the penis. I have always used common sticking-plaster. The rubber plaster might, however, I think, with advantage take its place.

THERAPEUTIC EFFECTS OF CHLORATE OF POTASSIUM. — Dr. Alex. Harkin, in an exhaustive paper on this subject in the Dublin Journal of Medical Science, says:

In tabes mesenterica the chlorate has a powerful effect, and in the diarrhea and dysentery of children, when given by the mouth and by enema, the most satisfactory results have been observed in my own practice and in that of the Vienna faculty, as published in the Rudolph Hospital Reports for 1869. Finally, in diseases of the skin, which generally are characterized by debility and a dyscrasis of the blood, the salt is a most potent remedy. In erysipelas no one is likely to question its value, particularly if combined with iron. It is equally useful in erythema nodosum, in eczema, in impetigo and purpura, in lupus when of scrofulous origin, in boils and carbuncles, in acne rosacea; and in that ailment so intractable and so troublesome to the fair sex, acne punctata, I have prescribed it with unvarying success. The remedy given internally appears to have a controlling power on the sebaceous glands and follicles, and prevents the usual progress toward suppuration. In acne rosacea the salt seems to combat the enlargement of the blood-vessels and congestion of the skin, on which the disease depends. In epithelioma and cancroid affections of the skin and mouth its efficacy as a lotion is generally acknowledged.

HYPODERMIC ADMINISTRATION OF QUININE.—Prof. Whittaker writes, in Cincinnati Lancet and Clinic:

During the past six months I have made numerous experiments with the subcutaneous injections of quinine in cases of pronounced or masked malaria, where the condition of the digestive system prevented its absorption when administered per os.

I have entirely discarded all vehicles except water, and rely solely

upon heat to obtain a perfect solution. Put into a test-tube twenty grains of the bromide of quinine and add to it two drams of water. The tube should be corked, not to preserve the substance—for it is still crystalline in this proportion—but for cleanliness. To use the drug, heat the tube over a gas flame, coal-oil lamp, or other means of illumination. The tube should be held above the light, of course, and not in it, that it be not smoked, and hence rendered opaque. Two or three minutes suffice to reduce the quinine to a limpid, crystalline fluid in the tube. Thence it is poured in sufficient quantity into a teaspoon, previously warmed by holding over the flame, and from the spoon it is taken up into the syringe, warmed also the same way, and ready for use, which must be immediate. It may be injected any where, but always *under* and never *into* the skin. The ordinary syringe contains half a dram, and this introduces about five grains at a time.

I have never known a patient to object to the reintroduction of the needle for the injection of ten or fifteen grains, if need be. The whole operation—no previous preparation being necessary—occupies about five minutes' time, not a tithe of that often consumed in irrelevant conversation.

THE GREEN COLORING-MATTER EJECTED FROM THE STOMACH.*—Dr. Betz states that the color of the green substance thrown up from the stomach is commonly explained to be bile. The color is gray-green, yellow-green, grass-green; sometimes dark-green. When the vomited mass is kept in a vessel for some time the green part settles; a portion, however, is suspended by bubbles in the phlegm. This green matter is heavier than and insoluble in water, whereas bile readily mixes with water. Chloroform and ether will not dissolve this green matter as it does the bile. This green matter remains undecomposed for a length of time during the hottest weather, and its reaction is not always acid, but, like the gastric juice, sometimes neutral and even basic. Dr. Betz concludes that the green color is (except in certain cases) not due to the presence of bile, but (other animal matter being excluded) to a vegetable substance, and revindicates the old name *vomitus massac herbaceæ*.

* Translated for AMERICAN PRACTITIONER from the Memorabilien, October, 1880, by Guido Bell, M.D., Indianapolis.

The green color is produced by chlorococcus, a dotted alga whose further development could not be observed. It does not seem to be in connection with *torula cerevisiæ* or *sarcina* or *oidium lactis*. Only the lepthothrix was seen sometimes within the mass, and resembles the green covering of the teeth, forming a matrix to lepthothrix buccalis. Dr. Clemens came to the same conclusion thirty years ago.

Clinically the following points have to be considered: (1) The quantities vomited are sometimes so large that they make the impression that the stomach can not contain so much bile; (2) The ways and means by which the bile can be carried into the stomach by pressure are not explained; (3) If the green substance is bile, then it would form a mechanical mixture, which is contradicted by the experiments given above.

The green mass appears the last on account of its specific gravity (or perhaps of its natural tenacity). The bitter taste is frequently observed in other fungi. Nevertheless the author does not deny that bile can reach the stomach under certain circumstances, but only exceptionally.

Salicylated Starch in Eczema.—Dr. Kersch, writing on salicylic acid, gives the following method for treating eczema: The scabs are to be removed by two-per-cent carbolic acid solution and castile soap, the parts are dried with cotton prepared for wound-dressing, then a two-per-cent alcoholic solution of salicylic acid is applied with the same cotton, and finally salicylated starch strewn over. Said starch is prepared by pouring pure starch in small quantity into a two-per-cent alcoholic solution of salicylic acid while stirring it for some time; then the alcohol should be poured off and the starch pressed in dense wool-flannel and dried at 80° C. Dr. Kersch gives a number of brilliant cases, and believes that former experiments with this remedy were not careful enough. (*Ibid.*)

Fracture of the Atlas.—Dr. Betz describes a case of fracture of the atlas which was followed by death fourteen weeks

afterward. There were no symptoms at first except a local pain, but symptoms of pressure, inflammation, and degeneration followed. A piece one half centimeter in length was broken loose from the posterior portion of the atlas, which had been pressing on the medulla. He refers to a case of Dr. R. Kline, saying that such a fracture does not always kill outright, as was formerly believed, and that it is worth some closer surgical researches. (*Ibid.*)

WICKERSHEIMER'S PRESERVING LIQUIDS.—

	For Injecting Bodies.	For Immersing Bodies.
Arsenious acid,	16 grams.	12 grams.
Sodium chloride,	80 "	60 "
Potassium sulphate,	200 "	150 "
Potassium nitrate,	25 "	18 "
Potassium carbonate,	20 "	15 "
Water,	10 liters.	10 liters.
Glycerin,	4 "	4 "
Wood naphtha,	¾ "	¾ "

(*Arch. d. Pharm.*)

The foregoing has been reported as being an inefficient preservative of subjects. The Ohio Medical Record advises Hegar's solution where a non-poisonous preservative is required. It has a pleasant odor, and exterminates moths and vermin. Hegar's solution is composed of salicylic acid, twenty parts; boracic acid, twenty-five; potassium carbonate, five; dissolve in hot water, five hundred parts; glycerin, two hundred parts; add oil of cinnamon and cloves, fifteen parts each; dissolve in alcohol, five hundred parts.

INJECTION BROU.—The following is believed to be the formula of the much-vaunted gonorrheal injection of that name, taken from the register in the French public offices:

℞ Zinci. sulp., ... grs. viij (.52);
Plumbi. acet., ... grs. xv (1.);
Tinct. catechu, ... ʒj (4.);
Tinct. opii, ... } āā ʒ iij (96.).
Aquæ, ... }

Notes and Queries.

THE JAPANESE QUACK.—We find the following description of the quack in the "Loyal Ronins," a curious and interesting romance translated from the Japanese and published by G. P. Putnam's Sons, New York: "No one is more to be pitied than he who places his life in the hands of a quack. Unfortunately many such foolish persons exist, because throughout all ages people have been more inclined to listen to rogues than to follow the advice of honest men. Must we not be cautious? There are many mock doctors to be found every where. These fellows, utterly ignorant of the science of medicine, which the ancients so closely studied and reduced to a system, pretend to cure diseases of which they do not even know the names, and entrapping their victims by a great show of books and scientific instruments, by threats and deceit, compel them to swallow the most nauseating compounds. If once in a while they make a hit the whole country rings with their praise, and they walk the earth with their heads in the clouds.

"The ancient professors of medicine established certain rules which are followed to this day. They first ascertained the comparative value of drugs, then mixed them in specified proportions, taking care that the effects of one ingredient should counterbalance the others, and thus produce a harmonious result. A patient suffering from fever requires medicines containing *in* (cold) properties, and one shivering with a chill should be dosed with *yo* (hot) drugs, to equalize the temperature of the system. However, a person afflicted with fever must not take only cold-producing physic, or the one who has a chill be treated with drugs that merely create heat. A skillful physician gives certain quantities of each remedy, in addition to which he uses acupuncture and the moxa. In the foregoing consists the science of medicine, which is only acquired by long study and

serving a number of years as assistant to a regular practitioner. Some drugs ought to be administered in their natural state; others require careful preparation, or their effects prove very injurious to the patient. Now a quack, not having studied these principles, blindly administers his nostrums, trusting to the god of luck to carry him through. If his patient dies he solemnly shakes his shaven head and says to the weeping relatives, 'I was sure of this from the beginning.'

"Beware of quacks! They live upon the weakness of human nature, and may be known by the long pole of their *norimono* (inclosed litter), their assumption of profound gravity, and the audacious manner in which they promise to cure most incurable diseases. At the same time they take care never to approach a person suffering from a contagious malady without having their sleeves stuffed with disinfectants, while their meanness is such they will keep their bearers walking all day, never so much as thinking to give the tired men a lunch or a cup of *saké*. There is another kind of quack who is too parsimonious to have a *norimono* or even a man to carry his medicine-case. These scarecrows trot around the streets from morning till night with their pockets puffed out with packages of nostrums, and slip through the crowds like eels between the rushes, as though in great haste to visit innumerable patients. Such creatures are well described by the proverb, 'A quack looks like a man who has stolen a cat and hidden it in his pocket.'

"My friends, if you wish to live keep away from the doctors; though in giving this advice I do not mean to assert there are no able physicians. These, like all good people, follow their profession quietly, and after performing a cure do not go clucking about like hens."

Prevention of Fogs.—Dr. C. W. Siemens has communicated to Nature a plan for remedying the growing evil of London fogs. The essence of the scheme is a reduction of the amount of coal consumed for domestic and other purposes. Dr. Siemens advocates the substitution of a special gas grate for the ordinary coal

fire. Two sketches illustrate the article and show at once the simplicity and efficiency of the plan. The two chief drawbacks to the gas grates in common use are the expense and the obnoxious fumes that are given off. Both these Dr. Siemens professes to have got rid of, and he claims for his plan an economy of heat, fuel, and money. When in use the cavity of the grate is filled with coke, which is heated by the jets of the gas flame. From some comparative experiments Dr. Siemens concludes that the coke-gas fire is not only warmer and cheaper than an ordinary fire, but is smokeless. "I hold," he states, "that it is almost barbarism to use raw coal for any purpose, and that the time will come when all our fuel will be separated into its two constituents before reaching our factories or our domestic hearths. Such a measure would not only furnish us with a complete solution of the smoke question, but would be of great value also as a money saving." Dr. Siemens generously adds that he has taken up this question without any idea of profit, and shall be happy to furnish builders and others desirous to introduce the coke-gas grate with the necessary indications to insure success.

National Association for the Protection of the Insane and the Prevention of Insanity.—The council of this important organization held a business meeting in New York City on the 11th of last November—Miss A. A. Chevailier, secretary; H. B. Wilbur, M.D., president; G. M. Beard, M.D., treasurer; Joseph Parrish, M.D.; E. C. Seguin, M.D.; Mrs. M. P. Jacobi, M.D.; J. C. Shaw, M.D.; Margaret A. Cleaves, M.D.; Hiram Corson, M.D.; Hon. L. L. Lamberton, LL.D. Doctors Jacobi, Cleaves, Seguin, and Shaw were appointed a committee to take steps to induce medical colleges, medical journals, and asylum authorities to do all in their power to diffuse a better knowledge of psychiatry among the profession, and to specially educate physicians who may desire a thorough knowledge of the subject. A committee was also formed to obtain facts and statistics relating to the methods and use of restraint and the use of labor in the asylums of this country. The purpose of this association

as expressed in the above plan of work can not fail to be of interest to every physician. The aim is to do more effective work by creating an organized protection for the insane of the whole country.

EDWIN BOOTH AS HAMLET.—The following compliment from the London Lancet to Mr. Booth may induce some of our readers who might not otherwise do so to witness, when they have opportunity, the representation of the melancholy Dane by one of the greatest living actors:

Although matters theatrical lie outside the domain of The Lancet, we have always made it a custom to direct the attention of our readers to every fresh exponent of Shakspeare's greatest character, because we feel that the study of this puzzling psychological fiction has perhaps more genuine interest for members of the medical profession than for any other class of persons.

Edwin Booth gives, we believe, a correct view of the Prince's mental condition. Of a sensitive and affectionate organization, he is profoundly affected, both mentally and physically, by his interview with the Ghost; and Mr. Booth succeeded in producing the impression, without any strain or effort, that this trying ordeal left an effect upon the nature of Hamlet so that, to use a common expression, he was never quite the same man afterward. His interview with Horatio and Marcellus after the disappearance of the Ghost was a really fine rendering of a most difficult part of the play, and from the time of the Ghost's exit to the fall of the act-drop it was evident that the mental shock had been terribly severe, that it was an effort to him to collect his thoughts, and that while conversing with his friends his mind was often far away.

For the rest, we must say that Mr. Booth's representation, although it was not marked by any very original or striking points, was, from a merely technical point of view, one of the best pieces of stage-performance we ever saw. The minutest syllable that Mr. Booth uttered, even in his most subdued tones, was, we believe, plainly audible in the far corners of the pit and gallery. To hear a fine voice, used with consummate skill, giving utterance to Shakspeare's masterpiece, is in itself a great treat—a treat which many popular Shakspearian actors quite fail to give us. Again, Mr. Booth's command of what is known as "stage business" we have never seen excelled. His actions were rapid, suitable, free from all exaggeration, and, if we may be allowed

the expression, exquisitely neat. The use which he makes of a pair of delicately-chiseled, nervous hands is such as any actor might envy. To give an example, his attitudes and manner while questioning his friends, in the first act, as to the circumstances of the Ghost's appearance to them, were at once masterly and easy. Mr. Booth has an expressive face and a fine figure, and his pronunciation is quite free from Americanism.

We beg leave to ask our very able transatlantic cotemporary whether he does not generally find the pronunciation of cultivated Americans, whether on or off the stage, free from what he is pleased to call Americanism?

JACKSONVILLE, ILL., December 31, 1880.

Eds. American Practitioner:

Please permit a brief comment upon the paper of Dr. Hibberd upon Typhoid Fever, in the December number of your excellent journal. The paper gives no treatment for the fever itself, and discourages doing much for the accidental symptoms. He says that during the current year he has treated a grave case in his own family, in which the only medicine given was twenty grains of quinia, two drams of Squibbs's deodorized tincture of opium, and four ounces of brandy. These remedies were for symptoms, and he scolds another man for giving seven remedies for symptoms. There is nothing in the paper to inspire confidence that there is any remedy for the disease. Indeed he says, "The contagium of typhoid fever having found a fruitful lodgment in the human system, the whole succession of phenomena must be concluded." He quotes Sir William Jenner as saying, "I have never known a case of typhoid fever cut short by any remedial agent."

In Beale's Archives, vol. v, No. 17, 1870, p. 61, may be found an article entitled "The Therapeutical Uses of the Sulpho-carbolates," by A. E. Sansom, M.D. In this article it is stated that from twenty to sixty grains of sodium sulpho-carbolate given every four hours can be borne without inconvenience. The urine under this administration gave no evidence of the presence of carbolic acid, though a considerable quantity of sodium

sulphate was found. The urine showed a remarkable tendency to resist putrefaction. The inference was drawn that the agent must be rapidly absorbed and carried through the system, the double salt being decomposed in the blood, the sodium sulphate escaping by the kidneys and the carbolic acid by the lungs. One fourth of the weight of the sulpho-carbolate of sodium is carbolic acid, and hence it is established that in this way from fifteen to ninety grains per diem of carbolic acid can be administered without exhibiting any poisonous effects.

My attention was attracted by this publication soon after it appeared, and I immediately commenced using sulpho-carbolate of sodium in typhoid fever. I soon fell into the routine of giving one dram (four grams) dissolved in half a tumbler of water every three hours, or one ounce a day. Regarding the product of the secretion of the lower portion of the ileum as poisonous to the system by the absorption of some of the fluid portion of the mass, I added to the routine a cathartic, every second day, of fluid extract of senna (with aromatics), regardless of the question of constipation or diarrhea. I inferred that the diarrhea depended upon the presence of irritating material, and that advantage would be gained by carrying it off; and experience soon proved the correctness of the inference.

This routine of an ounce of sulpho-carbolate of sodium in dram doses every day and three fluid drams of fluid extract of senna with aromatics every second day I have recommended to many friends, and I think that all have been pleased with the treatment who have been satisfied to follow it through. It must be borne in mind that there is no other manifestation immediately of any effect except a reduction of the temperature. The expectation of seeing any marked result must lead to disappointment. I have never seen a case exhibit alarming symptoms in which the treatment had been commenced early in the disease or previous to the manifestation of high temperature. In the absence of an epidemic it is customary to treat the cases as if they were malarial or remittent, and, failing in this, the diagnosis is supposed to be made out as against any disease for

which quinia is a remedy. The patient is then put upon the treatment for typhoid fever, and it is continued until the patient is far advanced in convalescence or as long as the thermometer exhibits high temperature.

Last autumn the wife of a laborer went through this course without being seriously sick, though she lay in bed two weeks. Her husband, on her recovery, began to feel a lassitude and anorexia, for which the liberal administration of quinine afforded no relief. Though walking about, he was put upon this treatment just the same as if he had been bedfast. It was three or four days before the symptoms began to abate, and he apparently went through the disease without going to bed in the daytime.

If we assume, as the best explanation of the observed phenomena, that the disease is dependent upon an infection arising from decomposing animal matter, whether solids and fluids, as in cesspools and dissecting-rooms, or gaseous, as in the breath retained in small apartments, or large apartments containing many people, or communicated from the sick to the healthy, and again assume that this infection may be destroyed by carbolic acid or other disinfectants, we have a foundation of an expectation of finding a remedy which, taken into the system, will arrest the further development of the material, whether organic or inorganic, which is the essence of the infection. If in sulpho-carbolate of sodium we have found a combination in which a patient can take fifteen grains of carbolic acid every three hours, or one hundred and twenty grains a day, without nausea or other unpleasant effect, and continue the treatment day after day until two pounds have been taken or half a pound of carbolic acid, we have found a remedy which answers the theoretic conditions. If, again, the observation of the employment of the remedy through several years, under the eyes of several physicians who are near enough to each other to compare experiences, fails to develop any unpleasant effect, and fails to encounter any serious or fatal case in which the remedy is commenced early and pushed through without omission or

abatement, we have a strong argument for the reversal of the verdict of the uncontrollability of typhoid fever.

Respectfully yours,

DAVID PRINCE, M.D.

OPERATIVE SURGERY.— Dieffenbach thus discoursed on a branch of that art of which he was so illustrious an exemplar (*Unsere Zeit Art.*):

Of all branches of medicine, operative surgery is the one most calculated to inspire its votaries with enthusiasm. It is the bloody warfare with disease for life, the struggle of life and death. It is not boldness and unfeelingness which here carry the day, but calmness and enthusiasm, knowledge and skill. Without being possessed with a certain natural disposition for this particular branch, without being thoroughly penetrated by it and feeling an almost unlimited devotion to it, its disciple will forever remain a mere tyro. He may be ever so well versed in the various disciplines of medical science, he may be ever so well acquainted with surgical operations in all their varieties and according to the best masters, he may be able to apply them to the corpse and even the living body; notwithstanding all this, he will never rise above the rank of a subordinate. What alone makes the true surgeon is this, that he knows and is able to execute what is not contained in fixed rules and formulas; that, always original, an inventive Odysseus, he knows how to create his own resources, and is ready at any moment, amid the most trying circumstances, to begin battle without previously holding a council of war. The painter is taught to draw, to mix his colors, and to put them on canvas, to make a correct copy; then he paints from his own ideas, he embodies his own thoughts and fancies. One might learn to make verses, but teaching can not make a poet; the poet is born. One might learn to use the knife, but frequently it is necessary to cut in a manner contrary to established rules and customs. Such is operative surgery.

THE BEST GENERAL PRACTITIONER IN LONDON.—The Canadian Journal's London correspondent says:

It is generally acknowledged that Mr. Jonathan Hutchinson is "the best all-round man" in London, as the saying goes. His manner of speaking is very quiet, but his views are expressed with great clearness and conciseness; at the same time there is the greatest candor, and no evidence of professional pride or obtrusive *egoism*. Both

his style and manner—in fact, the entire demeanor of the man—is a rebuke to the self-important, dogmatic, assertive class of medical practitioners. He is not ashamed to say before a class of medical students, "I do not know exactly what is the state of matters in this case." Mr. Hutchinson most explicitly believes that *erysipelas is not a specific fever.* His definition of erysipelas is, "An inflammation characterized by pitting and vesication with a definite outline, which has a strong tendency to shift its position." It is contagious, and arises *de novo.* He condemns local treatment by poultices, and prefers lead and spirit lotion. He lays great stress upon the statement that erysipelas has *no period of incubation.* Mr. Hutchinson's views on transverse fracture of the patella are at variance with the common teaching on this subject. They may be summarized thus: The greatest danger is from separation of the fragments by *effusion.* "There is no spasm of the quadriceps extensor." There is no special advantage in bony union, provided the fibrous or semi-osseous union be firm, as it generally is. The treatment is to be directed specially to getting rid of the effusion.

Prof. Lunsford P. Yandell, M.D., has withdrawn from the editorial conduct of the Medical News. Prof. Cowling now remains, as in the early life of our able and agreeable neighbor, sole editor, Dr. Cottell being added as managing editor. We regret to lose Dr. Yandell from the editorial lines, but are glad to know that the step was taken in consequence of an increase of professional work of a greater personal importance. Dr. Yandell is recognized as a pointed, forcible, and graceful writer, and in what he did on the News showed much judgment and a faultless taste. The readers of the News are to be congratulated on the fact that Dr. Yandell will continue as one of the regular contributors to our very progressive, marvelously good-humored, and most ably-conducted cotemporary.

A Simple Explanation.—Dr. John Brown, of Edinburgh—he who introduced us all to dear Rab and his Friends—tells the following anecdote: Walking through the grounds of a lunatic asylum one morning, he was accosted by one of the inmates. "You don't know me," said the lunatic. "No," said Dr. Brown, "who are you?" "I am Moses, the lawgiver," he replied. Ex-

pressing his pleasure at meeting the distinguished legislator, Dr. Brown continued his walk, and after a while fell in with the lunatic again. "You don't know me," he said. "No," said Dr. Brown again; "who are you?" "I am the Emperor Napoleon," he answered. "But," said Dr. B., "it was only fifteen minutes ago that you told me you were Moses, the lawgiver." "Certainly," replied the lunatic; "*that was by another mother!*"

A PURE DRINKING-WATER. — Professors Hofmann, of Berlin, and Kekule, of Bonn, and other chemists have published analyses of Apollinaris water, and all agree in showing that it is a very pure water, with about one quarter the quantity of alkaline salts contained in Vichy water.

FOR ASTHMA.—

℞ Ammonii bromidi, ... ʒ ij–ℨ ij;
Ammonii chloridi, ... ʒ iss;
Tr. lobeliæ, ... f ʒ iij;
Spts. etheris comp., ... ℥ j;
Syrup acaciæ, ... q. s. ad ℥ iv. M.

S. A dessertspoonful in water, repeated every hour or two during the severity of the attack. (Boston Med. and Surg. Journal.)

A NUMBER of reviews which have reached us too late for the present number will appear in our next.